South Gloucestershire Safer & Stronger Communities Strategic Partnership

JOINT DOMESTIC VIOLENCE HOMICIDE AND DRUG RELATED DEATH REVIEW

OVERVIEW REPORT

Into the death of Michael (pseudonym)

David Warren QPM, LLB, BA, Dip. NEBSS
Independent Domestic Homicide Review Chair and Report Author

Report Completed: 20th January 2016

The family's reflection on Michael

Michael's mother, who attended a Review meeting told the Panel that her son's death has devastated her, but that she finds comfort in the hope that the lessons learnt will reduce the risks for other people in the future. She asked that the following statement written by her son's teacher be included in the Review.

Teaching in a secondary school in a middle-sized town in ███ for almost forty years, I witnessed more than a few casualties of addiction. While each death is tragic and a source of profound loss and grief to the individual's family and friends, I am not alone in feeling that the loss of Michael (pseudonym) has an extra dimension of loss and an overwhelming sense of wasted human potential.

Academically, Michael was probably the most gifted of an impressive year group. It adds extra poignancy to his loss when so many of his former classmates are now high-achieving, happy young professionals all of whom would say, as a matter of fact, that "Michael was the brightest of us all". One of his closest friends graduated in Psychology in Trinity College, proceeded to MA and is now pursuing a Ph.D. He told me that it was his experience of Michael's life, in all its complexity, that drew him to study the workings of the human mind.

Although I knew Michael from his first year, I taught him for the first time in Transition Year, continuing into Fifth and the Sixth Year (Form). He had a lively response to literature, loved the challenge of a new poem or a scene in a play. If his attention wandered, all one had to do was to say: "now this is a bit difficult but what do you think …?" Immediately the head lifted! Occasionally one could see him holding back a response - part modesty, one felt, part consideration for others, and perhaps too the element of self-doubt that seemed deeply ingrained in his character. His Physics teacher states that he was the finest student she had encountered in her career and all teachers felt he was exceptionally bright.

Although insecure in himself in ways, Michael was protective of any isolated classmate, especially one vulnerable one whom he sometimes took home to be fed as there was neglect in that student's home. I feel that it is for his personality and character, rather than just his intellect, that Michael will be remembered. Even as he slid into addiction, starting early in Transition Year, Michael retained his innate good manners, his courtesy towards and consideration of others, a fact often commented on by the teachers and school secretary. He abhorred violence of any kind and became animated telling of a friend scaring a cat trapped in a shed. Although no actual violence occurred, his empathy with the creature led him to "freak" as he put it himself and insist on the cat's release. A small incident, perhaps, but one that I feel indicates his character.

Always well-groomed and in full uniform, in this, as in so many other ways, Michael confounded the stereotypical addict (if such a thing exists). It was, therefore, a matter of huge concern and regret when he started to miss school more and more until, finally, in Sixth Year, it became clear that he needed to concentrate on his mental and physical health. Visits to the house saw meals cooked, clothes being ironed, the house itself always spotless. It was clear that Michael was blessed with a caring, hardworking, supportive mother who was determined to do whatever she could to help him.

Attempts to rescue Michael's health included changing his GP, attempts to have him accepted into rehabilitation centres, admission to the psychiatric wing of ███████ in ███, visits to his house by myself and another teacher in an attempt to somehow pull him back into education and into the mainstream of life. There were several false dawns,

Michael in determined mode, saying that this time he just knew he was going to make it and, as he added so often, “make my mother proud of me”. She has every reason to be proud of the son she produced, although that pride must be matched by the depths of her sense of loss.

Just as we went into the chapel for Michael’s funeral, his mother asked me to say a few words about him. Unprepared, I had to pare it down to the bare truth of the young man I knew, including the addiction. When I thought of the many positives in his character, I had to ask myself: “Where did he get these qualities from?” The answer then, as now, is clear enough: from his mother. If eventually he went down a very dark road, that is due to the poisoning of his mind and body by drugs and drug dealers; it was not, as she says herself, the child she reared. In all the things over which she had control, His mother has no reason to feel guilt – only pride. The shame belongs elsewhere.

Written by Michael’s former English teacher (Year Head and Deputy - Principal) November 24th 2015.

Contents

1. Preface	6
2. Review Panel Members	8
3. Introduction	9
4. Parallel Reviews	13
5. Timescales	14
6. Confidentiality	15
7. Dissemination	16
8. Terms of reference	17
9. Schedule of Meetings	20
10. Methodology	21
11. Contributors to the Review	22
12. The Facts	24
13. Key Issues	31
14. Analysis	35
15. Effective Practice & Lessons Learnt	51
16. Conclusions	55
17. Recommendations & Action Plan	58

Appendices

Appendix A: Glossary of Terms

Appendix B: Bibliography

Appendix C: Coroner's Inquest Report

Appendix D: Bristol and South Gloucestershire Statistics re Drug Related Deaths

Appendix E: Lesbian, Gay, Bisexual and Trans Research Report January 2015

Appendix F: New focus on improving access to domestic abuse services for LGB and Trans communities

Appendix G: Research and engagement with young men exchanging and/or selling sex to men (Not yet published)

Appendix H: Lighthouse Integrated Victim Care Programme

Appendix I Chronology

1. Preface

1.1. The circumstances of Michael's (pseudonym) death meet the requirements for both a domestic homicide review and a drug related death review. South Gloucestershire Safer and Stronger Communities Strategic Partnership, being the body responsible to initiate both types of reviews has made the decision, with the agreement of the Home Office, to conduct a joint review.

1.2. Domestic Homicide Reviews (DHRs) came into force on the13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom she was related or with whom she was or had been in an intimate personal relationship or a member of the same household as herself; held with a view to identifying the lessons to be learnt from the death.

1.2. Throughout the report the term "domestic abuse" is used in preference to "domestic violence" (other than when quoting from official documents), as this term has been adopted by South Gloucestershire Safer and Stronger Communities Partnership.

1.3. The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.4. Drug Related Deaths are defined as "*A death where the underlying cause of death is poisoning, drug abuse, or drug dependence and where any of the substances are controlled under the Misuse of Drugs Act 1971"* (Office of National Statistics). The requirement to hold a Drug Related Death Review was initially established by the then National Treatment Agency in 2010, it has since been ratified by Public Health England.

1.5. The purpose of the Drug Related Death Review is to:

a) Prevent and reduce drug related deaths.

b) Identify ways to improve services, remedy system failures and develop opportunities for shared learning and challenge practices through interpretation of the details of individual cases and groups of cases.

1.6. This joint review examines the circumstances surrounding the death of Michael (pseudonym) in Wiltshire following a drug overdose on 27th May 2015 and was initiated by the Chair of the South Gloucestershire Safer and Stronger Communities Partnership in compliance with legislation. The Review process follows both the Home Office Statutory Guidance and that of Public Health England.

1.7. The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Michael and thank them, together with the others who have contributed to the deliberations of the Review, for their time, patience and co-operation. They also wish to thank Advocacy After Fatal Domestic Abuse (AAFDA) for the professional support provided to Michael's family who reside in [redacted].

1.8. The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies. He is joined by the Review Panel, in thanking Berkeley Wilde of the Diversity Trust for his invaluable advice regarding the Lesbian, Gay, Bisexual and Trans (LGB & Trans) community in Bristol and surrounding areas. Not least they thank Sophie Jarrett for the extremely efficient administration of this joint Review.

2. Joint Review Panel

David Warren QPM, Home Office Accredited Independent Chair

Dr Helen Cottee, Avon and Wiltshire Mental Health Partnership NHS Trust

Lorett Spierenburg, Avon & Somerset Constabulary

Maggie Telfer, Bristol Drugs Project

Jody Clark, Bristol City Council Substance Misuse Team

Claire Summers, National Probation Service

Sean Collins, North Bristol NHS Trust

Lisa Harvey, South Gloucestershire Clinical Commissioning Group

Catherine Boyce, South Gloucestershire Council Children, Adults and Health

Richard Capp, South Gloucestershire County Council Community Safety Team

Philippa Isbell, South Gloucestershire Council Community Safety Team

Sarah Telford, Survive South Gloucestershire and Bristol

Specialist Advisor to the Panel re the Lesbian, Gay bisexual and Trans Communities

Berkeley Wilde of the Diversity Trust.

Chair of South Gloucestershire Multi Agency Risk Assessment Conference (MARAC)

Charlotte Leason, Avon & Somerset Constabulary

Review Administrator:

Sophie Jarrett, South Gloucestershire Safer and Stronger Community Partnership

3. Introduction

3.1. This Overview Report of the South Gloucestershire Domestic Homicide Review examines agency responses and support given to the deceased Michael (pseudonym), an adult resident of South Gloucestershire and their contacts with Michael's partner Daniel (pseudonym), prior to Michael's death.

3.1.1. Michael, aged 24 at the time of his death, had been in a relationship with Daniel, who was 43 years of age, for approximately seven months. For six months they lived together at Daniel's home in South Gloucestershire.

3.2. This area in South Gloucestershire is a large suburb to the north-east of Bristol. It consists mainly of domestic housing and local shopping facilities, with little industry within its boundaries.

3.3 Incident Summary:

On Wednesday 27th May 2015 Michael and Daniel were travelling by car to London. They stopped at a motorway service station. Michael went off to the toilet while Daniel stayed in the car making work telephone calls. Michael was seen about twenty minutes later, wandering about with blood on his t-shirt. He looked as though he was hallucinating and having a panic attack. Wiltshire Police and an ambulance were called. On the arrival of the police he was lucid and conscious, the officers noticed that his eyes were dilated and his skin was pasty. Michael's condition gradually deteriorated resulting in cardiopulmonary resuscitation (CPR) being administered but without success. A doctor at the scene declared him dead, after having tried to revive him with a number of resuscitation drugs. It was deemed to be a non-suspicious death. Michael had a needle in his possession, another was found in the car and a third under the car. Daniel told the police that Michael, a user of heroin and crack cocaine, had been on methadone but had not had a prescription for ten days.

3.4. The post mortem toxicology report revealed that the cause of Michael's death was unnatural, being drug toxicity. The tests showed a significant concentration of morphine, together with other drugs including methadone, in his blood and urine. The Coroner's Inquest took place on 9th September 2015 and the Coroner held that Michael having taken a cocktail of drugs including heroin, methadone and cocaine died from a cardiac arrest.

3.5. On 7th July 2015 South Gloucestershire Safer and Stronger Communities Strategic Partnership together with Bristol Community Safety Partnership considered the circumstances of Michael's death i.e. That he had died of a suspected drug overdose and that days prior to his death there had been a referral to the South Gloucestershire Multi Agency Risk Assessment Conference (MARAC) as he had reported to the police, he had been subjected to domestic abuse by Daniel. Consequently the South Gloucestershire Safer and Stronger Communities Strategic Partnership Chair took the decision to undertake a joint Drug Related Death Review and a Domestic Homicide Review and the Home Office were informed on 8th July 2015. Later Public Health England were also notified.

3.6. The key purpose for undertaking this joint Domestic Homicide and Drug Related Death Review is to enable lessons to be learned from Michael's death. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand

fully what happened and most importantly, what needs to change in order to reduce the risk of such a tragedy happening in the future.

3.7. The Review considers all contact/involvement agencies had with Michael and Daniel during the period from 1st November 2012 and the death of Michael on 27th May 2015, as well as all events prior to that period which could be relevant to domestic abuse, violence, drugs or health issues.

3.8. The DHR Panel consisted of senior officers, from the statutory and non-statutory agencies, listed in section 2 of this report, who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the panel nor any of the Independent Management Report (IMR) Authors have had any contact with Michael or Daniel.

3.9. Expert advice regarding domestic abuse service delivery in South Gloucestershire has been provided to the Panel by Richard Capp, the South Gloucestershire Safer and Stronger Communities Senior Community Safety Project Officer and Sarah Telford of Survive, which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in South Gloucestershire. Specialist advice relating to illegal drug use has been provided by Jody Clark Bristol City Council Substance Misuse Team and Maggie Telfer, Chief Executive of the Bristol Drug Project. Specialist advice relating to Lesbian, Gay, Bisexual & Trans issues has been provided by Berkeley Wilde of the Diversity Trust.

3.10. The Chair of the Panel is an accredited Independent Domestic Homicide Review Chair. He has passed the Home Office approved Domestic Homicide Review Chair's courses and possesses the qualifications and experience required in section 5.10 of the Home Office Multi- Agency Statutory Guidance. He has an in-depth knowledge of illegal drug use having been the co-author of the first national drug strategy in 1998 and for several years was the chair of the registered charity "The 2 Bridges Drug and Alcohol Trust". He is totally independent and has no association with any of the agencies involved in the Review nor has he had any dealings with either Michael or Daniel.

3.11. The agencies participating in this Domestic Homicide and Drug Related Death Review are:

- Advocacy After Fatal Domestic Abuse
- Alliance Pioneer Medical
- Avon and Somerset Constabulary
- Avon and Wiltshire Mental Health Partnership NHS Trust
- Avon Fire and Rescue
- Bereaved Through Addiction
- Boots
- Bristol City Council Housing Advice Team

- Bristol City Council Safeguarding Adults
- Bristol City Council Substance Misuse Team
- Bristol Drugs Project
- Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Ltd.
- Cruse Group
- Diversity Trust
- Developing Health and Independence
- Great Western Hospitals NHS Foundation Trust
- LIFT psychology
- ManKind
- Merlin Housing
- National Probation Service
- NHS England
- New Law Solicitors
- North Bristol NHS Trust
- Places For People
- St. Mary's Academy,
- St Mungos Broadway
- Salvation Army
- Sirona Care and Health
- Solon South West Housing Association Limited
- South Gloucestershire Clinical Commissioning Group
- South Gloucestershire Council Community Safety Team
- South Gloucestershire Council Drug and Alcohol Action Team
- South Gloucestershire Council Children Adults and Health
- South Gloucestershire Council Environment and Community Services.

- South Gloucestershire Council Chief Executive and Corporate Resources
- South Gloucestershire Multi Agency Risk Assessment Conference (MARAC)
- South Western Ambulance Service NHS Foundation Trust
- Survive South Gloucestershire and Bristol
- Victim Support
- Wiltshire Police

3.12. From the commencement of the Review the DHR Chair has consulted with Michael's mother and friends. The victim's mother was provided with the details of the charity "Advocacy After Fatal Domestic Abuse" and has subsequently received regular support from the Charity. She has provided the Review with extensive information relating to Michael's life and given the names of Michael's friends from whom the Review also received significant information. The information provided by Michael's family and friends is included in section 12 of the Report and the information from the Deputy Principle of his old school is included in section 14. Michael's mother provided the Review with a consent form to allow the Review to access Michael's medical records.

3.13. The Chair of the South Gloucestershire Safer and Stronger Communities Strategic Partnership wrote to Daniel to inform him about the commencement of the Review, but received no response.

3.14. Both Michael's mother and Daniel were contacted at the conclusion of the Review. Michael's mother supported by AAFDA read the Overview Report prior to the Panel meeting on 3rd December 2015 which she attended. On 13th November 2015, Daniel was told of the lessons learnt, conclusions and recommendations of the Review but he declined the opportunity to read the report as he informed the review he is still receiving counselling as a consequence of Michael's death. He stated he loved Michael and did not accept that the relationship was volatile.

4. Parallel Reviews

4.1. The Coroner's Inquest was held on 9th September 2015. The Coroner concluded that Michael died after suffering a cardiac arrest as a result of taking a cocktail of drugs and alcohol. (See Appendix C). The Review Chair and a Panel member from the South Gloucestershire Safer and Stronger Communities Strategic Partnership attended the Inquest where they met with Michael's mother, cousin and their advocates from AAFDA.

4.2. There were no criminal proceedings initiated in relation to Michael's death.

5. Timescales

5.1. A decision to undertake a Domestic Homicide Review was taken by the Chair of the South Gloucestershire Safer and Stronger Communities Strategic Partnership on 7th July 2015 and the Home Office was informed on 8th July 2015.

5.2. The Home Office Statutory Guidance advises, where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review. Whilst the Review had planned to complete within this timescale on 3rd December 2015, a number of issues were raised which the Panel wished to have time to consider and a further meeting was arranged for 20th January 2016. The Home Office was informed of this delay.

6. Confidentiality

6.1. The findings of this Review are restricted to only participating officers/professionals, their line managers and the family of the deceased and their AAFDA advocate, until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

6.2. As recommended within the "Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews", to protect the identity of the deceased and his family, the following pseudonyms have been used throughout this report.

6.3. The name Michael is used as a pseudonym for the deceased, it was chosen by his mother. Initially the Review Panel selected the pseudonym Daniel for Michael's partner which was agreed at a later date.

6.4. The Executive Summary of this report has been carefully redacted. To enable the Home Office Quality Assurance Panel to have access to the detail of the Review, other than the use of pseudonyms and the exclusion of the names and addresses of involved individuals, the overview report and chronology have not been redacted. Both documents will be fully redacted prior to publication by the South Gloucestershire Safer and Stronger Communities Partnership.

6.5. The Review Panel has obtained the deceased's confidential information, (including police and UK medical records) after his mother gave her written consent. Daniel's medical records were initially disclosed through the public interest exception in S.29 of the Data Protection Act but he later signed a consent form allowing the Review access to his records.

7. Dissemination

7.1. Each of the Panel members (see list at beginning of report), the IMR authors, and Chair and members of the South Gloucestershire Safer and Stronger Communities Strategic Partnership have received copies of this report.

7.2. Michael's mother and Daniel were contacted at the conclusion of the review and informed about the outcome. Michael's mother took the opportunity to read the Overview Report and Executive Summary and attended the final meeting of the Review. Daniel did not wish to read the report or attend as he felt it would be too distressing, nevertheless he was told of the lessons learnt, conclusions and recommendations.

8. The Terms of Reference

8.1. Definition of a Domestic Homicide Review.

Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). States:

"Domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by;

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

8.2. Definition of a Drug Related Death Review.

A review into the circumstances of a death where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances controlled under the Misuse of Drugs Act 1971 are involved.

8.3. The purpose of the Domestic Homicide Review is to:

a) Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

b) Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse including their dependent children.

c) Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

d) Apply these lessons to service responses including changes to policies and procedures as appropriate; and

e) Prevent domestic abuse homicide and improve service responses for all domestic 17abuse victims and their children through improved intra and inter-agency working.

8.4. The purpose of the Drug Related Death Review is to:

a) Prevent and reduce drug related deaths.

b) Identify ways to improve services, remedy system failures, and develop opportunities for shared learning and challenge practices through interpretation of the details of individual cases and groups of cases.

8.5. The focus of both Domestic Homicide Reviews and Drug Related Death Reviews are therefore about identifying and addressing lessons to be learnt from the death, they are not about blame.

8.6. Overview and Accountability

8.6.1. The decision for South Gloucestershire to undertake a joint Domestic Homicide Review (DHR) and a Drug Related Death Review (DRDR) was taken by the Chair of the South Gloucestershire Safer and Stronger Communities Partnership, after discussion with partnership agencies, on the 7th July 2015 and the Home Office informed on 8th July 2015. The basis of the decision was that Michael had been referred to a Multi-Agency Risk Assessment Conference in relation to suspected abuse and there is reason to believe that he died as a result of taking an illegal drug.

8.6.2. The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review. While there are no set time scale for the completion of DRDRs they should be concluded expeditiously so that lessons learnt can be addressed promptly.

8.6.3. This joint review which is committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

8.7. The Review will consider

8.7.1. Each agency's involvement with Michael, 24 years of age at time of his death on 27th May 2015 or with his partner Daniel. Agencies involvement should include any contacts between 1st November 2012 and 27th May 2015; and any contacts relevant to domestic abuse, violence, drug or health issues prior to that period.

8.7.2. Whether there was any previous history of abusive behaviour towards the deceased or to any previous partner of Daniel and whether these incidents were known to any agencies or multi agency forum?

8.7.3. Whether either Michael or Daniel had any previous history of dependency on any legal or illegal drug and whether either had or were receiving support or treatment from any specialist drug support or treatment agency.

8.7.4. Whether family, friends or neighbours want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or any concerns relating to drug abuse, prior to the death?

8.7.5. Whether, in relation to the family member's friends or neighbours; were there any barriers experienced in reporting domestic abuse or drug abuse?

8.7.6. Could improvement in any of the following have led to a different outcome for Michael?

a) Communication and information sharing between services.

b) Information sharing between services with regard to the safeguarding of adults and children.

c) Communication within services.

d) Communication to the general public and non-specialist services about available specialist services.

8.7.7. Whether the work undertaken by services in this case are consistent with each organisation's:

a) Professional standards.

b) Domestic Abuse policy, procedures and protocols.

c) Drug abuse policy, procedures, protocols or treatment.

8.7.8. The response of the relevant agencies to any referrals relating to Michael or Daniel concerning drug abuse, domestic abuse or other significant harm from Daniel, or to any other incident relevant to drug abuse, violence or domestic abuse prior to that date. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with the deceased or his partner.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.

d) The quality of any risk assessments undertaken by each agency in respect of Michael or Daniel.

8.7.9. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly in this case.

8.7.10. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

8.7.11. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

8.7.12. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8.7.13. The review will consider any other information that is found to be relevant.

9. The schedule of the Domestic Homicide Review Panel meetings is:

- 4th September 2015, 0930 -1300, Kingswood Civic Centre
- 19th October 2015, 0930 - 1630, Kingswood Civic Centre
- 3rd December 2015, 0930 - 1330, Kingswood Civic Centre
- 20th January 2016, 0930 - 1300, New World Business Centre, Warmley

10. Methodology

10.1 This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) and Reports of participating agencies;
- The Pathologist
- The Coroner
- Members of the deceased’s family, friends
- The deceased’s partner
- Discussions during Review Panel meetings.

11. Contributors to the Review

11.1 Whilst there is a statutory duty that bodies including, the police, local authority, probation trusts and health bodies must participate in a DHR; in this case forty organisations have contributed to the review (listed in Para. 3.11). Twenty-four have completed Individual Management Reviews (IMRs) or reports. The deceased's partner, mother, friends and school teacher have also provided information to the DHR.

11.2 Individual Management Review Authors:

Mathew Davey, Alliance Pioneer Medical

Julie Mills, Avon and Somerset Constabulary

Michael Dunne, Avon and Wiltshire Mental Health Partnership NHS Trust

Matt Hunt, Avon Fire and Rescue

Elaine Parfitt, Boots

Richard Wadsworth, Bristol City Council Housing Advice Team

Steve Jackson, Bristol Drug Project

Sarah Shatwell, Developing Health and Independence

Gary Addie, New Law Solicitors

Sean Collins, North Bristol NHS Trust

Karen Potter, Places for People

Patrick McGovern, St. Mary's Academy

Jenny Riley, St Mungos Broadway

Jody Clark, Bristol City Council Substance Misuse Team

Helen Roper, Salvation Army

Geoff Watson, Sirona Care and Health

Ellie Gooch, Solon Housing

Dr Kate Mansfield, South Gloucestershire Clinical Commissioning Group

Caroline Goodwin, South Gloucestershire Council Children Adults and Health

Rosie Collins, South Gloucestershire Council Drug and Alcohol Action Team

Charlotte Leason, South Gloucestershire Multi Agency Risk Assessment Conference (MARAC)

Amanda Robinson, South Western Ambulance Service NHS Foundation Trust

Detective Inspector Phil Staynings, Wiltshire Police

Dr Darko Lazic, Pathologist's Report

12. The Facts / Information

12.1. Michael's mother informed the Review that she brought up Michael and his brother (who was 5 years older) in [redacted], mainly on her own. The boys' father had left the family when Michael was a small child but remained in contact with his sons. Michael's mother knew he was gay from an early age. The Deputy Principal of his school, who had known and taught Michael for seven years, described him as "perhaps the brightest pupil in his school year".

12.2. Michael informed various agencies in Bristol that he started to use drugs from an early age; his teacher informed the review that he first started to smoke cannabis when he was about fifteen years of age and quickly progressed to taking other drugs including heroin. These had an adverse effect on his school work and attendance. He eventually left school without completing his education or taking his leaving certificate.

12.3. The Review was told by Michael's family and teacher that when he was in his late teens Michael was admitted to the psychiatric wing of a hospital in [redacted] where for a short time he seemed to make progress in tackling his drug dependency, however he was later discharged, in keeping with the hospital's policy, after being found drunk and in possession of a half bottle of vodka.

12.4. Michael's friend told the review that Michael later travelled abroad and lived in [redacted] for a period. His family have little detail of his movements during this time, however Michael had told Daniel, he had been involved in an unhappy relationship in [redacted], where due to his heavy drug use, he became paranoid of the people close to him, this resulted in him being compulsory admitted for hospital treatment.

12.5. In October 2012 Michael moved to Bristol with a friend. On 24th October 2012 he self-referred to the Compass Centre, a Bristol "street population" outreach support service, run by St. Mungo's Broadway. Michael was provided with information regarding emergency accommodation and was given an appointment for a full assessment for 25th October 2012 as he had stated he had stopped drinking alcohol the previous night and felt he was experiencing alcohol withdrawal symptoms. He did not attend the appointment but did go the following day and had a full initial assessment. He said he had been sleeping rough in a park for three nights after a relationship breakdown. He explained he had previously been living in a hostel in [redacted], [redacted] and left there to live with his partner in Bristol. He did not want to return to [redacted]. During the assessment he also discussed his support needs, which included mental health due to depression. He said he was feeling low because of his situation. He did not disclose a history of self-harm but the assessor noted old cuts on his arms that may have been evidence of previous self-harm. He talked about his substance misuse which included heroin and alcohol. When the risk assessment was being completed he was asked about domestic abuse or abuse from others and he said he was not at risk from these issues. He did say he wanted to have support to remain abstinent from drugs. He was provided with details on drug and alcohol agencies, given assistance in setting up a benefits claim and was referred to a shared dry house where a room had been reserved for him.

12.6. With the help of the Bristol City Council Housing Advice Team, on 1st November 2012 Michael moved into a [redacted] in Bristol and while there he requested a referral to the Salvation Army Bridge Rehab (now closed) and was transferred there on 20th November 2012. He informed the staff that since the age of about 17 he had a history of high

usage of heroin, benzodiazepine and alcohol. While on the Bridge programme he was referred for substitute prescribing and appeared motivated to achieve abstinence though he did struggle with this. Subsequently Michael received several warnings for non-engagement with the programme and these together with the non-payment of his service charge, resulted in his eviction from the Bridge programme on 19th February 2013.

12.7. In April 2013 Michael received individual support from the Places for People Charity. With their help, Solon Housing found him a flat in Bristol through the City's "Rough Sleepers Initiative". He was given an assured short term tenancy agreement for a maximum of two years and was provided with weekly direct tenancy support. He was recorded as "leading a chaotic life, using drugs and alcohol heavily". Neighbours complained about his drug use and the smell of this. On one occasion, 7th November 2013, the Fire and Rescue service were called to put out a hob fire in his flat. No one was injured.

12.8. Michael's friend told the Review that due to Michael's chaotic drug and alcohol use he could not obtain regular employment; however rather than turning to crime, he took up sex working to fund his drug use.

12.9. On 5th March 2013 Michael first registered with an NHS GP. As there is no automatic transfer of medical records between █████ and the UK knowledge of his previous medical history came from information provided by Michael in a new patient questionnaire. His history of drug use and prescribed dosage of substitute therapy prior to registration, was reported to the practice by his support worker. Consequently Michael started receiving a prescription from his GP for daily supervised administration of subutex and zopiclone and later methadone.

12.10 In May 2013 Michael was arrested for shoplifting and was given a police caution.

12.11. On 15th July 2014, following a consultation at his GP practice, in which he gave a history of past psychiatric problems which had previously not been known to the GP practice, a request for past medical notes was sent from Michael's GP to his last known doctor in █████. It is of note that this was one of very few routine booked appointments that Michael had with the practice, the majority of his consultations being emergency/duty doctor appointments. The response from the doctor in █████ was that Michael had not been seen at the practice since September 2012 and that release of any records would require Michael's written consent. Michael did not write that consent and no records were received.

12.12. Between 5th March 2013 and 8th December 2014 Michael had 48 face to face consultations with 18 different GPs at one GP Practice; this is a result of Michael using the emergency/duty doctor appointments rather than routine bookable appointments. His medical record shows that all 18 GPs tried to encourage him to use the routine bookable appointment system so that he would have continuity of care from one or two doctors.

12.13. On 7th November 2013 Michael contacted the police to report a verbal domestic incident whereby his ex-partner was making threats towards him. The ex-partner left the flat while Michael was on the telephone and he then declined to give the police any further information.

12.14. On 5th December 2013 Michael was first referred by his GP to the Bristol Drug Project (BDP). Five days later whilst in custody for burglary (due to lack of evidence no

further action was taken) he was subject to a positive test for Class A drugs. Consequently he was assessed by the Avon and Wiltshire Mental Health Partnership NHS Trust's (AWP) Criminal Justice Intervention Team (CJIT). Michael told the CJIT worker that he was injecting heroin and smoking crack cocaine daily. A comprehensive care plan was agreed after careful risk assessments were conducted. BDP organised opiate substitution treatment and his CJIT worker arranged housing support and motivational work.

12.15. Michael attended several appointments with both BDP and his CJIT worker and on 24th December 2013 he was referred by the BDP Shared Care Team to the Bristol Specialist Drug and Alcohol Service (BSDAS) core service for preparation for specialist prescribing and for the Recovery Group. However, after this meeting Michael failed to respond to telephone calls and letters from his CJIT worker and from his housing support worker.

12.16. On 13th January 2014 a CJIT worker called at Michael's address and spoke to him. He agreed to attend a further appointment and was seen on 23rd January 2014. Michael confirmed his prescription had been increased and he would reduce the amount of drugs he was using on top of his prescription. He said he wanted to do something constructive and the CJIT worker told him about the Prince's Trust with the view to a referral when Michael was more stable.

12.17. On 24th January 2014 Michael was arrested and cautioned for possessing a Class B drug. He missed his appointments with his CJIT worker and when he was eventually contacted on the telephone on 21st February 2014 he told the worker he had been in a car collision and had injured his neck.

12.18. On 10th March 2014 Michael was arrested for shoplifting in Boots while attending for his supervised prescription of methadone. While in Police custody he was seen by a CJIT worker after testing positive for opiates. He said he was feeling very low as he had missed his brother's funeral (this was not true) but was not suicidal although he had self-harmed previously. An offer of bereavement counselling was made but he did not wish to pursue it.

12.19. On 2nd April 2014 Michael was given a conditional discharge for 12 months at Bristol Magistrates Court. The same day Michael was discharged from CJIT. He continued to engage with BDP Shared Care in accordance with his care plan.

12.20. In May 2014 Michael made two calls to the police. The first call related to his then partner leaving his flat and taking Michael's iPhone and other personal items. Officers made numerous attempts to contact Michael by visiting the flat, telephoning and texts but eventually filed the complaint as they could not contact him. Thirteen days later Michael again contacted the police to report that he had been raped by his ex-boyfriend; he stated the ex-boyfriend and another friend had been with him that day. Michael sounded drunk and kept leaving the phone, eventually he told the operator that the offender had left and he did not want any further action. The Operator, concerned about his welfare, sent officers to the flat. He appeared to the officers to be under the influence of either alcohol or drugs but he confirmed that nothing had happened that evening and that he did not want any police action. When pressed, he said if he changed his mind he would go to the police station.

12.21. On 18th July 2014 Michael reported his bag stolen whilst he was with a friend in a Bristol park. Initially he had been unaware the bag was stolen, the crime was filed.

12.22. On 21st July 2014 as Michael had not engaged with either Solon Housing or Places for People, in accordance with registered social landlord procedures a notice requiring possession was served. After Michael failed to respond to visits and letters from both Solon and Places for People, an order for possession was given on 14th November 2014. At that time he owed £1950 in rent arrears. On 19th January 2015 a Court bailiff attended at the flat to change the locks and it was then apparent that Michael had already abandoned the property, although large numbers of used needles and syringes were left at the premises.

12.23. Daniel informed the review that he met Michael on 3rd October 2014. This correlates with Michael's account on 7th May when Michael informed the police that he had met Daniel 7 months previously via Grindr (social dating application) where he was advertising himself as a male prostitute (this is the term as per the police report to reflect the wording used by Michael). Daniel informed the review that they liked each other and subsequently went out regularly on dates. During that time he states Michael told him he was addicted to heroin but wanted to give up. Daniel stated that he offered to support him to do this. After approximately three weeks Daniel said Michael moved in with him.

12.24. On 11th October 2014 Michael was mentioned to the Police as being involved in a robbery. The alleged victim failed to provide the police with a statement and failed to return calls left for him to contact the police. Eventually a decision was made to take no further action and to file the complaint.

12.25. On 15th October 2014 a member of the public called an ambulance after Michael was found, unconscious outside a taxi office in Bristol. The ambulance staff treated Michael and ascertained that he had taken methadone, crack and Gamma Hydroxy Butyrate Acid (GHB).

12.26. Between July 2014 and May 2015 Michael attended 24 appointments with the BDP Shared Care Team.

12.27. Michael continued to collect his methadone prescription from Boots throughout 2014 and 2015 with numerous gaps until 25th March 2015 when after being aggressive with the Pharmacist and being suspected of stealing he was warned that if it continued he would be banned. There are no records of him returning.

12.28. On the morning of the13th January 2015 Michael and Daniel had a verbal argument. Both contacted the police. Daniel told the police that they had been in a relationship since October 2014 saying that Michael was a drug addict, whom he was trying to help to get clean. He said that Michael had been visiting a friend who had got him back into drugs. This caused an argument during which Daniel contacted Michael's mother, which annoyed Michael. The incident was initially recorded as threats by Michael on Daniel. However when Michael claimed Daniel had pushed him (no injury) this was amended. A DASH risk assessment was carried out in relation to Michael with the risk set as 'medium'. In accordance with the Avon and Somerset Constabulary Procedural Guidance on Domestic Abuse, Michael was recognised as a vulnerable adult and flagged on the police data system "Guardian" to receive an 'enhanced service' in accordance with the Victims Code of Practice (VCOP). A background check on Daniel revealed that he had been involved in two 'verbal domestics' with an ex-partner in 2008. The following day, Michael stated that he was no longer pursuing a complaint of assault as the couple had 'made up' and he requested that the police should "stop ringing him, as this amounted to harassment". He did not answer the telephone thereafter. Evidence in the case was reviewed by a supervisor and assessed to be

weak. Michael had refused any contact with the officer in the case. Without support from the victim it was determined that there was no further action to be taken. The report was closed on 22nd January 2015 and the matter filed. A referral to the Lighthouse Victim and Witness Care scheme was nevertheless made where it was recorded that no further police action was to be taken. Daniel told the Review that this incident was due to Michael, who normally only used heroin and methadone, being encouraged to smoke crack cocaine by his friend in Bristol. Daniel claimed Michael became aggressive when he took crack.

12.29. On 5th February 2015 during an appointment with BDP, it was noted that Michael's partner Daniel stayed for much of the session. The worker stated "In my opinion there are control issues within the relationship but the partner agreed to leave when I asked. Michael said they do argue and last night Michael left and went to stay with ex-partner. Michael reports being slapped and almost strangled by his partner. "I have talked through options of safety with Michael but he would like to stay and try and make the relationship work." Daniel told the Review Michael had asked him to go with him, so that he could see for himself that he (Michael) was trying to control his drug use. Michael's chaotic drug use had strained their relationship and the patience of their non-drug using friends who witnessed how Michael was when he had taken crack in particular.

12.30. On 17th February 2015 Michael was referred to the North Bristol NHS Trust Department of Plastic Surgery from the Minor Injuries Unit. He reported he had punched a wall nine days previous. He was suffering from a fracture to the right metacarpal shaft. Treatment was a plaster cast and to be referred to the Hand Service and for physiotherapy. On 2nd March 2015 when he returned for the removal of the cast he said the injury was caused by a fall rather that punching a wall. He was given further advice and another appointment to check progress, however he did not attend two further appointments and was subsequently discharged from the Hand Clinic.

12.31. On the 19th February 2015 BDP notes state "Michael reports domestic abuse in relationship and pressure for unprotected sex. He has asked today for support in accessing the men's Crisis Centre. "I have given Michael the number and let him know he can self-refer and that they can call me for further information regarding his care." It was noted on 14th April 2015 that Michael chose not to contact the Crisis Centre as he was permanently staying at his partner's address. Michael confirmed that he was permanently living at an address in South Gloucestershire and therefore needed to transfer to a GP surgery local to his address; arrangements were made by BDP shared care for this to happen under the 4 week transfer protocol and a prescription was issued for the following 4 weeks.

12.32. On 24th April 2015 Daniel contacted Developing Health and Independence (DHI) about Michael's drug use and family and carer support triage was completed. It was recorded that Daniel spoke about Michael's aggressive behaviour and worries about finances and Daniel suffering chest pains. Daniel was given an appointment for an assessment on 7th May 2015. (However it was not possible to conduct the assessment that day due to Michael being arrested.)

12.33. On 5th May 2015 an abandoned 999 call was made to the police at 10.59pm. The police operator re-called the number and it went to answerphone. A male then called back and said he did not want the police, he just wanted some advice. Intelligence checks were carried out and it was discovered that the call was made from a number previously used by Michael. It was noted that Michael was a vulnerable adult, due to domestic abuse. He had

been assessed according to the DASH risk assessment tool as at ‘medium’ risk of harm with a ‘treat as urgent’ marker being placed on his home address. A further call was attempted to ask whether the caller was safe. There was no reply. A mobile police unit was dispatched to the address, where the male confirmed that he had called 999 however he did not want police and was unsure why the operator put him through to the police. He stated that he ‘just wanted some advice’. The officers attending were satisfied that all was in order. No further action was taken.

12.34. During the early hours of 7th May 2015 Daniel called the police as Michael had been taking crack cocaine and was disturbing him. He was advised that if it continued the police would attend and remove Michael. A DASH risk assessment was completed with a medium risk being recorded. The police were later called again and Michael was arrested for breach of the peace. Daniel had said that Michael had punched him three times. When the police were leaving with Michael, Daniel became upset and asked why Michael was being taken into custody as he did not want him to go.

12.35. Following Michael’s release from custody he told the officers that Daniel had been subjecting him to physical, emotional and mental abuse for five months. He said this happened when Daniel got drunk, Michael refused to give any further information. Nevertheless the officers offered a support agency referral but Michael declined the offer. The Officers recorded that Michael and Daniel were in a relationship. As the officers deemed that Michael was at risk of abuse from Daniel a rapid response marker was placed on the premises and the police Lighthouse initiative was tagged. A DASH risk assessment was completed with a high risk score and it was referred for discussion at the South Gloucestershire MARAC on 21st May 2015.

12.36. Later on 7th May 2015 Daniel told the DHI Family and Carer Worker that Michael had been arrested after he had phoned the police because of Michael’s aggressive behaviour. Daniel requested support to contact BDP or BSDAS for treatment for Michael. He was advised that DHI would call him later to arrange another assessment appointment.

12.37. On 12th May 2015 Daniel had a brief pre-assessment meeting with DHI. He reported being unable to make contact with BDP to arrange for a methadone prescription for Michael. He again complained of a chest pain and was advised to seek an emergency GP appointment. He also reported an escalation in Michael’s drug use. It was agreed to meet fortnightly and an appointment was made for full assessment on 15th May 2015.

12.38. Also on 12th May 2015 South Gloucestershire Council Adult Safeguarding Access Team received a report from the police that when Michael had been arrested to prevent a breach of the peace he had disclosed that he suffered abuse from his partner and that there were concerns about his mental health. A senior practitioner discussed Michael’s situation with the police officer who had dealt with him and as they did not have a mobile telephone number for him, she wrote to offer an assessment as a means of providing an opportunity to engage with him.

12.39. On 19th May 2015 Daniel telephoned DHI to say that he could not contact BDP on the phone. There was a fault on BDP telephone lines and DHI arranged for someone from ROADS Advocacy Service to contact Daniel which was done the same day. Daniel was advised to encourage Michael to sign on with a local GP as soon as possible so that he could obtain a prescription for methadone.

12.40. On 21st May 2015 Michael's situation was discussed at the South Gloucestershire MARAC. It was agreed that the police would carry out a welfare check and advise Michael to register with a GP. They should also check if anyone else is living at Daniel's address and feedback to the South Gloucestershire Safeguarding team.

12.41. On 22nd May 2015 Michael contacted the Adult Safeguarding senior practitioner by telephone in response to her letter and told her that his home situation was "dire", his partner was violent and he would like to leave. He said he was currently registering with a new GP. The Panel later learnt this was not done. After discussing the urgency of the situation, Michael agreed to meet with a social worker on 26th May 2015. In preparation for that meeting the social worker discussed with South Gloucestershire Housing an option of emergency housing, however Michael did not turn up for the meeting. On 27th May a manager from the adult safeguarding team at South Gloucestershire Council contacted police and requested a welfare check for Michael following his non-attendance. Police made numerous attempts that day to contact Michael at home but to no avail.

12.42. A full chronology of agency contacts with Michael and Daniel is included in Appendix J of this Report.

13. Key issues arising from the review

13.1.The Review Panel, having had the opportunity to analyse the information obtained from agencies, from Michael's family and friends, from Daniel and from the Coroner's Inquest, consider the key issues in this Review to be;

<u>13.2. Michael's mental health.</u>

13.2.1. Michael's mother told the Review that Michael suffered a period of depression in his mid-teens due to his drug dependency and his inability to find work. For a short time he was an inpatient in the psychiatric wing of a hospital in ██████, but this was in connection with his drug and alcohol use rather than for mental health issues. It has been reported by Daniel and a friend of Michael's that Michael told them both on separate occasions, that for a while he had lived in ██████ where he had been in an unhappy relationship mainly due to his excessive drug use. They also stated that due to the drugs and their quantity he became paranoid of the people around him and eventually was taken into hospital in ██████. The Review has not been able to trace any records of this.

13.2.2. After he moved to Bristol in October 2012, during his assessment to obtain a place on the Salvation Army's Bridge detox programme, he stated he had previously suffered from depression. However as the Bridge has closed, it has not been possible to check if his mental health was ever explored whilst he was on the programme. On another occasion he told his Places for People support worker that he had previously had mental health problems and she recorded that there were marks on his arms akin to old self-inflicted cuts. He was not asked about them. At a GP consultation in 2014 he gave a history of past psychiatric problems. A request for past medical notes was sent to his last known doctor in ██████. The response was that Michael had not been seen at the practice since September 2012 and that the release of any records would require Michael's written consent. This was never given and no records were received. GPs repeatedly recorded trying to get Michael to book a normal surgery appointment which would have provided opportunities for further disclosure regarding his mental health, however he continued to use the open access/duty doctor appointments which being shorter are not so suitable for review of complex ongoing problems or continuity of care.

13.2.3. Michael's friend in Bristol, said that Michael did not enjoy his work as a male sex worker and would often feel low. The Review's Lesbian and Gay, Bisexual and Trans (LGB&Trans) communities adviser has highlighted research which indicates that LGB and Trans people experience disproportionate levels of anxiety and depression and demonstrate a higher likelihood of substance misuse than other people. (See Lesbian, Gay, Bisexual and Trans Research Report January 2015, Appendix E).

<u>13.3. Michael's vulnerability as a sex working male and through his drug and alcohol use.</u>

13.3.1. Michael and his elder brother were brought up as practicing Catholics. Michael was allegedly introduced to drugs at an early age by his brother. Although very bright, by 15 years of age Michael's school work started to suffer as he moved from cannabis use to heroin, benzodiazepine and alcohol; he subsequently left school with no qualifications. Information provided to the review indicates that he tried several times in both ██████ and Bristol to give up drugs and to reduce his alcohol intake but at the time of his death was unable to sustain those changes and was still problematically using drugs and alcohol.

13.3.2. Michael rarely used crime to fund his drug and alcohol usage, turning instead to sex working, advertising in the online contact app "Grindr". He was described by his friend, as very handsome and popular with his male clients, who would pay him a minimum of £70 a session with tips on top. His friend said that while Michael was aware of the dangers he faced in this work, he took precautions by refusing to have unprotected sex or to indulge in some of the more bizarre requests made by clients. He did not like his work and his friend speculated if this was the reason for his drug binges and why he was so keen to stay with Daniel and make that relationship work. Michael had a previous partner who he told the police had taken some of his property and been violent towards him. Michael also told the police about a historic rape. No action was taken as Michael refused to give names or details and there was no forensic evidence available. Nevertheless the police did recognise his vulnerability and later referred him to both Adult Safeguarding and to the MARAC.

13.3.3. The Diversity Trust has completed a discussion paper highlighting the vulnerability of young men engaged in the male sex trade. (See unpublished research "RESEARCH AND ENGAGEMENT WITH YOUNG MEN EXCHANGING AND/OR SELLING SEX TO MEN" by the Diversity Trust 2015 Appendix G**)**

<u>13.4. The number of drug related deaths in Bristol and South Gloucestershire and whether there is any evidence of possible links between them.</u>

13.4.1. Drug related deaths during 2014/2015 only slightly increased from previous years. All of the deaths attributed to overdose were opiate related. No evidence has been found to indicate any connection between Michael's death and the other recorded drug related deaths in Bristol or South Gloucestershire. This is considered in more detail in paragraphs 14.6 to 14.8 and 16.4 of this report. The reports from the Bristol and South Gloucestershire Drug services commissioners are included in full in Appendix D. The "Lesbian, Gay, Bisexual and Trans Research Report" prepared for the Bristol Recovery Orientated Alcohol and Drug Service by The Diversity Trust in January 2015 (see appendix E) indicates that LGB people demonstrate a higher likelihood of being substance dependent.

<u>13.5. How drug treatment services engage with someone who is leading a chaotic life which results in him regularly missing appointments.</u>

13.5.1. According to his mother and his teacher, Michael twice went into residential drug and alcohol treatment in ■■■■■ and after promising starts on both occasions he relapsed and become more chaotic in his usage. After moving to Bristol, this recurred throughout his treatment journeys, initially being eager to be abstinent then reverting to chaotic use of illegal substances and missing appointments. Each agency that has provided the Review with an IMR has reported on the regularity with which Michael missed appointments with drug treatment agencies, hospitals, housing support and the police. On occasions when he missed key appointments he resorted to using inaccurate information relating to the welfare of his mother and brother to explain why he missed them. Drug agencies are particularly well practiced in maintaining contact with clients who regularly miss appointments, or drop out of services for a period. They remain non-judgmental and keep the door open through risk reduction initiatives such as needle and syringe exchange schemes, whereby clients can find it easy to re-engage in core support services. Michael used this route back into services more than once. This is recounted in section 14 of this report.

13.6. Daniel's relationship with Michael and their relationships with previous known partners.

13.6.1. Michael and Daniel first met after Daniel responded to Michael's advert in the contact application "Grindr." Daniel gave him a large tip on top of his fee and invited him out socially afterwards. Michael's friend told the Review that Michael and Daniel hit it off immediately and weeks later Daniel invited Michael to live with him. Daniel's ex-partner still lived in the house together with another male lodger. It is clear from the information provided by agencies, Michael's mother and his friend that Michael and Daniel's relationship was at times volatile, with both contacting the police and making allegations about each other. Daniel believed that Michael's drug dependency was the key cause of their disagreements and arguments and there is evidence from AWP, BDP and DHI records that, although he was viewed as being controlling by Michael's BDP support worker, he made active attempts to get Michael back on methadone prescriptions. Yet at the same time, he funded Michael's purchase of drugs to stop him being tempted to commit crimes or to go back to sex working. It is noted however that Michael's mother told the Review that shortly before his death, Michael had told her on the phone that, "Daniel had made him stop using methadone and he was now using heroin again". Michael told his drug worker, the police and a social worker that Daniel was controlling and on occasions hit him. This has been confirmed by friends after his death. Michael was offered support to leave Daniel by agencies including Bristol Drug Project, South Gloucestershire Adult Services and by the Police (who also made a MARAC referral). Repeatedly however once Michael had told an agency that he wanted to leave Daniel he would change his mind stating he wanted the relationship to work and he would stay with Daniel. (This is a common occurrence in the domestic abuse field and individuals need to feel supported and safe to leave).

13.6.2. Daniel told the Review that since Michael's death he has been receiving regular counselling. He cannot get over Michael's death as he had loved him and believed Michael had loved him. He did not accept that their relationship was volatile, he stated they were happy together except when Michael took drugs, particularly crack. Daniel has said that when Michael was like that, it strained their relationship, as he tried to get Michael to stop using and Michael would lie to him that he was stopping, but never did.

13.6.3. A Police background check on Daniel revealed that he was involved in two 'verbal domestics' with an ex-partner in 2008. No action had been taken. Michael had also reported a previous partner to the police for a historic rape but did not provide any further information stating he did not want any police action.

13.7. Whether agencies did not recognise domestic abuse as being an issue because of Michael being male and/or his being in a same-sex relationship.

13.7.1. It is clear that the police and South Gloucestershire Adult Services accepted that Daniel and Michael were in a same-sex relationship and that Daniel's behaviour amounted to domestic abuse. Four organisations, Bristol Drug Project, North Bristol NHS Trust, South Gloucestershire Clinical Commissioning Group and Sirona Care and Health acknowledged that Michael being a man in a same sex relationship may have hindered him from being recognised as a victim of domestic abuse.

13.7.2. The Review notes the findings of Professor Marianne Hester OBE, in a study aimed at finding out whether there is an association between men who have experienced or carried out

domestic violence and abuse with men visiting their GP with mental health problems or who are binge drinking and using cannabis says: "Research on domestic violence and abuse has largely focused on women and there is a lack of research on men, both as victims and perpetrators. The findings from this study are important as they suggest that when men present to GPs with anxiety or depression, they should be asked about domestic violence and abuse as there is a higher likelihood that they will be victims or perpetrators. The findings are consistent with previous studies, which found that mental health problems are more common in men who either perpetrate or experience domestic violence and abuse, and serve as an important indicator to clinicians." (Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey by M Hester, G Ferrari, S K Jones, E Williamson, L J Bacchus, T J Peters and G Feder in BMJ Open. 19 May 2015)

14. Analysis

14.1. Agencies completing IMRs and Reports were asked to provide chronological accounts of their contact with Michael and/or Daniel prior to Michael's death. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of Reference. The Review focuses on the contacts of agencies from 1st November 2012 when Michael first moved to Bristol to 27th May 2015 the date of his death, together with relevant information prior to that time. The recommendations to address lessons learnt are listed within the action plans in section 17 of this report.

14.2. The Review Panel has checked that the key agencies taking part in this Review have domestic abuse policies and is satisfied that those of the statutory and specialist domestic abuse organisations are fit for purpose. The need for other organisations to introduce domestic abuse policies is addressed in the recommendations. The Panel is also satisfied that the specialist drug treatment and support services that have participated in the Review provide quality services in line with the requirements of their commissioners and the needs of clients, in accord with the direction of Public Health England.

14.3. The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of eliminating discrimination, fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the Terms of Reference.

14.4. Forty agencies/multi-agency partnerships were contacted about this review. Nineteen have responded as having had no relevant contact with either Michael or Daniel.

They are:

- Bereavement Through Addiction
- Bristol City Council Safeguarding Adults
- Bristol City Council Substance Misuse Team
- Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company Ltd
- Cruse Group
- Diversity Trust
- Great Western Hospitals NHS Foundation Trust
- LIFT psychology
- ManKind
- Merlin Housing
- National Probation Service
- NHS England
- South Gloucestershire Council Community Safety Team

- South Gloucestershire Council Environment and Community Services.
- South Gloucestershire Council Chief Executive and Corporate Resources
- South Gloucestershire Council Drug and Alcohol Action Team
- Survive South Gloucestershire and Bristol
- Victim Support

14.5. Two of those agencies provided the Review with expert assistance.

14.5.1. The Diversity Trust was asked to provide the Review Panel with specialist advice regarding the Lesbian, Gay, Bisexual and Trans community in Bristol and surrounding areas and in particular with regard to male sex workers.

14.5.2. Secondly the Review Panel was concerned that Michael's mother, who lives on her own in [redacted], was not in receipt of any support or assistance. The Review Chair contacted Advocacy After Fatal Domestic Abuse (AAFDA) and the Chief Executive of the Charity agreed to provide her with help. The Review Panel acknowledges AAFDA's unstinting support and professional advocacy on the family's behalf with both the Coroner and with this Review.

14.6. Two other organisations, Bristol City Council Substance Misuse Team and South Gloucestershire Council Drug and Alcohol Action Team, had no contact with either Michael or Daniel. However as the commissioners of drug and alcohol services in Bristol and South Gloucestershire they have provided the Review with reports detailing the number of drug related deaths in their respective areas in line with the requirements of Public Health England guidance on drug related death reviews.

14.6.1. Bristol City Council Substance Misuse Team cited that since 2007/08 an average of thirty deaths per year have been reported in the Bristol area. On average 60% are identified as drug related with opiate overdose being the biggest causal factor although rarely in isolation from the use of other substances. Forty one deaths were reported in 2015 and whilst three await toxicology/cause of death, the proportion that were drug related is expected to be broadly in line with previous years. All of those deaths attributed to overdose were opioid related.

14.6.2. South Gloucestershire Council Drug and Alcohol Action Team maintains records of drug and alcohol related deaths known to the South Gloucestershire Treatment Services. They have recorded that in 2014/2015 there were twenty five deaths of which five were recorded as drug related. During January to September 2015 there were five deaths of individuals who were open to treatment services at the time of their death. Two died through natural causes, one was alcohol related and as yet with regard to the other two the cause of death has not been confirmed although one is a suspected drug overdose. There is no evidence that any of the drug related deaths in South Gloucestershire were connected in any way.

14.7. Twenty-one organisations have provided Individual Management Reviews and Reports. The Review Panel has considered them carefully from the view point of Michael and Daniel to ascertain if each of the agencies' interventions were appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all of the lessons have been identified and are being properly addressed.

14.8. The Panel is satisfied that the authors of the IMRs and Reports have followed the Review's Terms of Reference carefully and addressed the points within it where relevant to their organisations. The Panel is also satisfied that each author has been honest, thorough and transparent in completing their reviews and reports. The following are the analysis of each report together with in the Review Panel's opinion on the appropriateness of the agency's interventions.

14.9. Alliance Pioneer Medical

14.9.1. On 27th May 2015 an ambulance owned by Alliance Pioneer Medical was taking a patient to London. At the request of the patient the ambulance stopped at the motorway service station. On arrival the ambulance was flagged down by members of the public. The two ambulance men, one of whom was an NHS trained paramedic, went to a part of the carpark where they found two police officers performing CPR on Michael who was lying on his back. The police officers told them he was not breathing, there was no pulse and he was unresponsive. The two ambulance men assisted in opening Michael's airways by putting a tube into his throat. Within five minutes they were joined by a South Western Ambulance Service ambulance crew and a doctor from the Wiltshire Air Ambulance. They remained at the scene until the doctor pronounced Michael's life extinct about 20 minutes later. They made comment about how distraught Daniel was while this was happening.

14.9.2. The Review Panel is satisfied that the two ambulance personnel from Alliance Pioneer Medical did all they could to assist in reviving Michael and there are no lessons to learn from their intervention.

14.10. Avon and Somerset Constabulary

14.10.1. The Police IMR author has analysed all of the contacts the police had with Michael and Daniel (as listed in the chronology and detailed in section 12 of this report) and tested them against the Review's Terms of Reference.

14.10.2. The IMR author is satisfied that during Police responses to Michael's and Daniel's calls relating to domestic abuse, officers consistently followed the relevant Force procedural guidance. She did however highlight there were difficulties due to both Michael and Daniel making initial calls then refusing to explain the nature of their complaints, so that many incidents were closed as "no offences disclosed". Nevertheless there is evidence that calls were responded to promptly and that officers followed them up with safety visits and the correct advice was given relating to the availability of support. DASH risk assessments were completed appropriately in each incident and officers recognised and recorded their concerns regarding Michael's vulnerability.

14.10.3. On the occasions that Michael was arrested for property offences he was dealt with in accordance with good practice and tested for drugs. When the tests proved positive he was referred to the multi-agency Criminal Justice Intervention Team (CJIT) which provided access to drug and alcohol treatment for offenders.

14.10.4. Whilst the police responses were positive and caring there was nevertheless a lesson to be learnt in relation to trying to contact Michael by text, which is detailed in section 15 of this report. The police also acknowledge the need for a review of specialist services being available for same-sex domestic abuse victims and for male prostitutes.

14.10.5. The Review Panel thanks the IMR author for her thorough report and concurs that the Avon and Somerset Constabulary responses to calls made by either Michael or Daniel complied with force policy and practice. During the course of this Review allegations were made to the Review which related to domestic abuse Michael had been subjected to which had not previously been reported. These allegations were passed to Avon and Somerset Constabulary who have subsequently interviewed four witnesses. The Panel has been made aware of the progress of this investigation and is satisfied that it is being conducted expeditiously and in line with correct police practice.

14.11. Avon and Wiltshire Mental Health Partnership NHS Trust

14.11.1. The IMR author identified that Michael had involvement with two of Avon and Wiltshire Mental Health Partnership's services; the Bristol Criminal Justice Intervention Team (CJIT) and with the Bristol Specialist Drug and Alcohol Service (BSDAS).

14.11.2. Bristol CJIT provided one-off required assessments for individuals arrested and testing positive for Class A drugs, rapid prescribing for people coming out of prison, and care-coordination for individuals coming into contact with the criminal justice system with substance misuse issues. The team delivered time-limited psychosocial interventions as part of key-working, and would refer to other appropriate agencies for on-going work.

14.11.3. BSDAS provides assessment and treatment to individuals with substance misuse issues and complex needs which includes co-morbid serious mental health, homelessness and pregnancy.

14.11.4. Bristol CJIT and BSDAS had limited contact with Michael. He missed or re-arranged at least half of his appointments and he was at times difficult to contact. Proactive attempts were made by CJIT to contact Michael by telephone when he did not attend, though these were often unsuccessful. On one occasion the CJIT worker called at Michael's address to check on his well-being and offer another appointment and there was liaison with the housing provider when the worker was unable to get a telephone response from Michael. Although Michael engaged well in the psychosocial work that was being undertaken in his CJIT sessions, his lack of regular attendance limited the usefulness of the work.

14.11.5. There appears to have been a lack of awareness between BDP and the CJIT team about each other's involvement, at least initially when BDP referred Michael to BSDAS. At the time that these services were operating, a new service delivery model had just been commissioned and changes were being implemented at an operational level as a result of this. In November 2013, Bristol Recovery Orientated Drug and Alcohol Service (Bristol ROADS) was commissioned. This was designed to provide service users with a seamless recovery journey, accessing a range of newly commissioned services, which included CJIT, BSDAS and BDP.

14.11.6. A new consent form was developed, which explained to service users that consent to share information, means consenting to share within the whole of the treatment system, which from November 2013 included Bristol CJIT. Additionally, all commissioned providers were required to use a shared electronic case record system. This has resulted in significant improvements in communication between drug and alcohol provider agencies.

14.11.7. In April 2014 there were changes to the criminal justice commissioning which meant that the CJIT team were commissioned to provide a more limited and defined input. The team was no longer able to provide the case management function or see service users for longer-term psychosocial work and therefore Michael was closed to CJIT and his care transferred to BDP shared care for follow-up. The CJIT worker liaised with BDP regarding this transfer and an appropriate referral was made on the shared case record system. The IMR author acknowledged that in retrospect, more proactive ways of engaging service users in this transfer could be sought.

14.11.8. The Review Panel notes that while Michael was under the care of Avon and Wiltshire Mental Health Partnership's services there were significant changes taking place to endeavour to improve the care coordination of clients. The Panel is satisfied that the IMR author has identified the lessons to be learnt from the implementation of those changes and that the recommendations made are appropriate.

14.12. Avon Fire and Rescue

14.12.1. The Avon Fire and Rescue Service had only one contact with Michael when they attended a hob fire at his flat in Bristol on 7th November 2013. There was no suggestion that the fire was deliberate and the IMR Author is satisfied that the response was in accordance with the service's accepted procedures.

14.12.2. The Review Panel accepts that there are no lessons for the Avon Fire and Rescue to learn from this incident.

14.13. Boots

14.13.1. The IMR author has gathered information from the pharmacists at two Boots Pharmacies, one in Bristol and one in South Gloucestershire and from the pharmacy patient medical records and entries in the controlled drug registers.

14.13.2. Michael's first contact with Boots was on 5th April 2013 when he signed a contract for supervised daily administration of subutex, and zopiclone. After 16th April 2013 there was no further contact until 7th January 2014 when he signed a new contract regarding the supply of supervised medication of methadone. On 10th March 2014 he was banned and arrested for shoplifting in the store. A week later he was allowed back for his daily prescription of methadone. However his attendance at the pharmacy was sporadic with on occasions months going by without him turning up. On the 4th November 2014 he started to attend a Boots Pharmacy in South Gloucestershire for his daily supply of methadone. The last record of methadone supply was on 23th April 2015.

14.13.3. The IMR author was satisfied that staff followed company procedures for the dispensing and supply of prescribed medication and for supervising the consumption of medication when requested. However it was highlighted that while all patients have a two way agreement with the pharmacy, there is no three way agreement that involves the patient's GP or drugs team which would make it easier to manage and provide a better level of care. It was also noted that it would be helpful if pharmacies were notified of all cases on substitute prescribing.

14.13.4. The Review Panel is satisfied that company procedures for the dispensing and supply of prescribed medication and for supervising the consumption of medication when requested were properly followed. The Drug services commissioners on the Review Panel noted the points made regarding the need for a protocol for three way communication between the GP/Drug Treatment Service, the Patient and the Pharmacy and for pharmacies to be notified of all cases on substitute prescribing.

14.14. Bristol City Council Housing Advice Team

14.14.1. In October 2012 Michael was referred to the Bristol City Council Housing Advice Team and was placed in a hostel prior to being found a flat in a low-support placement, managed by Places for People. The IMR author was satisfied all actions were carried out in accordance with the Department's policies and practice.

14.14.2. The Review Panel accepts that there are no lessons for the Bristol City Council Housing Advice Team to learn.

14.15. Bristol Drugs Project (BDP)

14.15.1. Michael's contact with BDP began in January 2013, with his presenting to the direct access service and needle exchange. BDP has an Advice Centre that is open six days a week that can be accessed without an appointment by those that need advice, entry to treatment programmes or support. A Needle & Syringe Programme (NSP) is offered during the opening hours at this address. Interventions with Michael were primarily around his use of the NSP for much of 2013, this was focused on the provision of sterile injecting equipment and reducing the risks that his use of substances might cause.

14.15.2. During the course of his engagement during 2013 he took the opportunity to get Hepatitis B vaccinations and to see nursing services to address issues related to an infection around an injecting site wound. Direct access service is recorded if it involves use of NSP and where specific issues around health, wellbeing and risk of harm are evident. The lack of record beyond the NSP use and occasional comment shows that Michael's use of BDP services was limited to meeting need around regular NSP use. Between January 2013 and the first recorded referral to treatment services (made by his GP on 5th December 2013), he used the NSP twenty-eight times in total. During these visits efforts were made to ensure that Michael knew where he could get other needs met, including considering starting treatment to address his use of heroin. There are notes in June 2013 that lifestyle changes were discussed with Michael during his visits to the NSP.

14.15.3. Michael's assessment by the ROADS service, following the referral from his GP, indicated that he needed treatment in the shape of opioid substitute treatment. Opioid substitution treatment (OST), involves the provision of substitute medication, a longer acting but less euphoric opioid, to those physically dependent on opiate drugs (usually heroin). This is delivered in Bristol in a partnership between primary care and the ROADS treatment programmes. Those referred to the service, by their GP, are prescribed by their GP with ongoing therapeutic interventions provided by a Shared Care worker from BDP, seeing patients within the GP Practices. Michael's assessment was delivered at his GP surgery on 11th December 2013. Following the assessment he was re-started on an OST prescription for methadone. His BDP shared care worker made a referral to BSDAS. His BDP worker believed that Michael's disclosure that he was selling sex represented a vulnerability that

needed recognising and made the more intensive nature of intervention offered at BSDAS the appropriate response to Michael's needs. Michael did not attend for this appointment.

14.15.4. Michael around this time had also engaged with the Bristol Criminal Justice Intervention Team (CJIT), following being arrested. He had disclosed that he had outstanding criminal justice issues at assessment but did not mention any involvement with CJIT. His first appointment with BDP shared care was not until 18th December 2013 so it is likely that his involvement with them did not begin substantively until this date. Michael's treatment continued to be provided by his GP, with regular supportive input and psycho-social interventions from CJIT. This situation continued until Michael was discharged by the CJIT service in July 2014. Michael's treatment was interrupted soon after being taken onto the Shared Care caseload, due to his failure to collect his daily methadone dose and his missing an appointment with his Shared Care worker. Contact was re-established when he visited BDP's Advice Centre and was able to get a "re-start" arranged with the surgery. As Michael made contact soon after his prescribed treatment (OST) had been interrupted, the regime was able to be speedily re-established, following the guidelines for the provision of OST, without the need for a full reassessment.

14.15.5. Michael’s use of the NSP had continued throughout the year but had been less frequent with seven visits recorded between December 2013 and July 2014. Michael's continued use of heroin, while being prescribed methadone, was responded to with titration of his methadone dosage upwards in an attempt to reduce the frequency of his heroin use. This practice is in line with NICE Guidance (widely known as the “Orange Book”) and Public Health England (PHE) guidance "Medications in Recovery: best practice in reviewing treatment (2013) and 'Optimising Opioid Substitution Treatment (2014). His reduced use of the NSP is evidence that this approach had some success.

14.15.6. In October 2014 the first recorded mention of Michael's (unnamed) partner was noted, when he cancelled an appointment saying that he had taken his partner to hospital to seek treatment on an injured ankle, explaining that the injury had occurred the previous day when the injured party had fallen down some stairs "during an argument". Michael's next appointment was a month later, and his missing this without explanation led to enquiries with the pharmacy from where he collected his methadone daily. This revealed that he had in fact taken his latest prescription to a different pharmacy, in South Gloucestershire (i.e. out of Bristol treatment area) and had been regularly collecting his methadone dose from there. Michael later explained that he had been staying in South Gloucestershire with a new partner. Michael was advised that he would need to find a pharmacy within the Bristol area in order for treatment to continue, with the alternative of transferring treatment after registering with a GP in South Gloucestershire.

14.15.7. Michael missed his December 2014 appointment with his Shared Care worker and was next seen on 8th January 2015 by a covering Senior Practitioner from the Shared Care team. Michael was accompanied to this appointment by Daniel, and asked the worker if Daniel could sit in on his appointment. This was agreed, although they were advised that this did not set a precedent for all future appointments. Nevertheless on 5th February 2015 Daniel again accompanied Michael at his appointment.

14.15.8. This appointment was with his regular Shared Care worker. Responding to a feeling of disquiet about issues of controlling behaviour, she asked to see Michael alone for the final part of the session. She discussed her observations with Michael who acknowledged that

there had been arguments and that he had been slapped and "almost strangled" by Daniel. Michael said that he had left and stayed with his ex-partner but had returned and wanted to try to make the relationship with Daniel work. He said this in response to attempts to explore options of safety by the Shared Care worker. Michael confirmed that he regarded the South Gloucestershire address as his permanent one and accepted that this would lead to his treatment needing to be transferred to services there.

14.15.9. Following conversation with the prescribing GP, a decision was made by the GP and Shared Care worker to make a referral to the specialist drug and alcohol prescribing service within ROADS (BSDAS). The decision followed concerns regarding continued use of heroin and crack cocaine by Michael and an escalation in his consumption of alcohol. Meanwhile his engagement with his Shared Care worker would continue. At his next appointment, on 19th February 2015, he repeated allegations that his relationship was characterised by domestic violence, and that he was feeling pressured into unprotected sex by Daniel. Michael asked for help in accessing a crisis centre locally and was given contact details to make a self-referral there. (The organisation has confirmed to the Review, that Michael never contacted them for help.)

14.15.10. Michael did not engage with BSDAS, missing his initial appointment and not responding to their attempt to contact him and so his treatment continued via GP and Shared Care. At his appointment on 17th March 2015 he said he had decided not to pursue alternative accommodation and his intention was to remain at Daniel's address. Arrangements were thus put in place to transfer Michael's Opioid Substitution Treatment to a GP surgery local to his address. The transfer was to be completed in line with the ROADS "Operational Guidance". This guidance recommends that when a transfer is required treatment should be provided for a maximum of between 4 and 6 weeks to cover transitional arrangements. Michael was accordingly provided with methadone prescriptions for the next four weeks and the necessary transfer form to be handed to the new surgery when he registered as a patient there.

14.15.11. Michael did not register at the new GP Practice as arranged. On 20th May 2015 he attended BDP's Advice Centre where liaison between staff and Michael's Shared Care worker established that his treatment had effectively ended as his prescription had expired before he had registered at a GP surgery local to his address. He was advised how to do this and offered a fast-track response to re-establish treatment once he had done so. He had attended BDP with Daniel, but staff spoke to him on his own. He had discussed a desire to find alternative accommodation, again referring to violence and control that he was subject to from Daniel. He was assured that he could re-establish treatment with any surgery in Bristol local to any address he went to, after he had suggested he might seek to stay with a friend rather than stay longer at Daniel's. He left agreeing to contact BDP once he had completed a registration with a GP surgery. Michael used the needle exchange during this visit and was given appropriate advice about making any use of heroin as safe as he could.

14.15.12. The final contact that Shared Care had with Michael was in a phone call made at the request (by e-mail) of Daniel. Michael said that he had begun the registration process at the South Gloucestershire GP practice near to Daniel’s home (this was not true) but that a lack of ID had delayed him completing it. Arrangements were made for an appointment being available to Michael for a reassessment and re-start of treatment.

14.15.13. Michael was last seen at BDP on 27th May 2015 when he used the needle exchange (NSP). Nothing remarkable was recorded by staff on this date.

14.15.14. The Panel acknowledges the IMR author's open and very detailed account of Michael's contacts with BDP. They accept that while there is evidence of excellent practice and joint working in relation to core business, the IMR author has rightly highlighted the lessons to be learnt in relation to what action to consider when a male client in a same sex relationship discloses domestic abuse. The Panel is satisfied that the recommendation being implemented by BDP will properly address these issues.

14.16. Developing Health and Independence (DHI)

14.16.1. The IMR author did not find any significant deficiencies in the quality of support provided by DHI to Daniel regarding family carer service, in relation to his wanting to support Michael in re-engaging with drug services to get methadone prescription reinstated.

14.16.2. In Daniel's triage assessment notes of 24th April 2015 it was reported that Michael was using crack cocaine on top of this methadone script; also that he had been spending a lot of time with drug taking acquaintances and that his paranoia and aggressive behaviour was escalating.

14.16.3. The planned assessment on the 7th May did not take place with Daniel due to DHI staff sickness. The assessment was re-booked for the 15th May however there is no record of this taking place. A full assessment would have explored more thoroughly the extent of Daniel and Michael's circumstances and a more in depth risk assessment would have been completed at this point. However there is clear evidence that Daniel was offered and engaged with ongoing support from DHI between the 24th April and the date of Michael's death on 27th May 2015, both face to face and by telephone/text.

14.15.4. The case notes indicated that Michael had recently moved in to live with Daniel. Text exchanges between Daniel and his Key Worker on the 19th May 2015 stated that Michael had been encouraged, but had so far failed to register with a new GP since his move, although he did appear to have been allocated a new shared care worker linked to the new GP practice. For this reason there was a lack of clarity in relation to who/how Daniel might support Michael to get his methadone prescription renewed.

14.15.5. DHI communication with Daniel was pro-active and regular and relationships between DHI and partner agencies was positive and effective. However, there are a number of lessons to be learned in relation to the timeliness of assessment and in particular risk assessment; a clearer analysis of the severity of Daniel's presenting circumstances may have helped to expedite Michael's access/engagement with treatment services. The IMR author highlighted that lessons could also be learnt in relation to cross border information sharing. While the South Gloucestershire MARAC contacted DHI in South Gloucestershire regarding Michael's referral, Bristol DHI were not contacted and there was no way for South Gloucestershire DHI to know of the information held by Bristol DHI relating to Michael as their records were recorded under Daniel's name on their data base.

14.16.5. The Review Panel is satisfied that DHI complied with their policies and set procedures, providing support to Daniel who they viewed as Michael's carer and liaising with BDP to address Daniel's concerns regarding Michael's drug use. The lessons learnt and recommendations made are deemed appropriate.

14.17. New Law Solicitors

14.17.1. Michael's solicitor confirmed that the company had acted on behalf of Michael in a personal injury claim relating to a car accident in which he had been a passenger. Michael had received minor injuries and the claim was settled after his death. After legal fees, the residue of the settlement (between £500 to £600) was paid to his mother. (Allegations had been made by Michael's friend that Michael had received approximately £17000 which had been paid in to Daniel's bank account, the solicitor was clear that was not the case).

14.17.2. The Panel accepts that there are no lessons to learn or recommendations to be made by the firm.

14.18. North Bristol NHS Trust

14.18.1. After injuring his hand, Michael attended two appointments where he was seen by healthcare staff. He initially stated he had punched a wall. This is not an uncommon presentation to a Minor Injuries Unit. He was referred to the appropriate secondary hospital service and subsequently seen by the hand service at Southmead Hospital.

14.18.2. The North Bristol NHS Trust does not carry out routine screening of patients to ask them if they are the victims of domestic abuse. So the practice of the clinical team member not to question how the injury was caused, was in-line with the Trust's policy and procedure. However even if routine screening was being carried out, it would not have considered Michael as he would not have been identified by the trust as being a member of a recognised high risk group.

14.18.3. In addition to the entries on the medical records. Michael was discussed at South Gloucestershire MARAC on the 21st May 2015. The North Bristol NHS Trust is a contributing partner to this MARAC and should have shared the information in the Trust's possession with regard to Michael. It is clear that no information was shared. This has been investigated by the IMR author and the named nurse for Child Protection but no explanation for the lack of discloser has been established. It was a practice error.

14.18.4. The Review Panel accepts that the identified failure to notify the MARAC of the hand injury, whilst regrettable, would not have influenced the MARAC's actions. The Panel is satisfied that the recommendations made are appropriate.

14.19. Places For People

14.19.1. The Report author confirmed that Michael was supported by them from April 2013 until January 2015 when he was formally evicted from his flat by Solon South West Housing Association. From Michael's notes and from interviews with the team who worked with him, it was apparent that he led a chaotic life, using drugs, drinking heavily and taking risks around his personal safety when out. Nevertheless, while due to his drug habit he was hard to engage with at times, there was very little criminal activity recorded and no record of him getting into any serious trouble.

14.19.2. The Review Panel accepts that Places for People complied with their policies and practices in their dealings with Michael and that they made clear efforts to maintain contact with him.

14.20. School in ■■■■■

14.20.1. The School's Deputy Principal provided a report relating to the seven years Michael was at the school. He described Michael as "turning the stereotype of a drug addict on its head. While he struggled with drugs and alcohol addiction from his mid-teens, he was unfailingly polite and respectful to all his teachers and never interacted negatively with any fellow student. Increasingly his non-attendance was a serious problem and eventually he left school without completing his course or taking his leaving certificate. This was all the more regrettable as he was among the brightest (possibly the very brightest) of a bright year group. He was regarded as such by his classmates, several of whom have remarked over the years that throughout his primary schooling he was a cut above the others. His primary school teacher and the Principle of the primary school concur with that opinion."

14.20.2. The school helped arrange for Michael to be admitted to the psychiatric wing of a Hospital in ■■■■■ where he seemed to make progress in abstaining from drug and alcohol for a short time. However on a day out he purchased and drank a half bottle of vodka. On being found drunk he was discharged from the programme in keeping with hospital policy.

14.20.3. The Review Panel has been impressed by the steps taken to help Michael and has expressed their thanks to the Deputy Principal (now retired) for providing this very balanced report into Michael's school life.

14.21. St. Mungos Broadway

14.21.1. Michael went to St. Mungo's Compass Centre in October 2012 and presented as being "street homeless"; his housing history, support needs and potential risks were fully assessed. The assessment concluded that Michael did not meet the criteria for referral to the Local Authority for statutory housing under the Housing Act 1996. He was therefore referred as a rough sleeper to supported accommodation that was suitable for his support needs and he was accommodated within nine days.

14.21.2. Michael had been using various substances since the age of 17 and was referred to appropriate services for support around this including the Salvation Army Bridge Programme. Michael's mental health was assessed and monitored. He was not assessed as being a high risk of harm to himself. There was a potential opportunity to refer Michael to a mental health support service, however his primary needs were assessed as being accommodation and support with his drug and alcohol problems. His mental health needs could have been explored further once he was accommodated by a provider who would fully assess his support needs on moving in and he would feel more settled rather than when he was sleeping rough.

14.21.3. The assessment noted Michael had been using substances since the age of 17. He did not discuss any triggers that may have resulted in using substances. At the time of Michael's assessment the Bristol Outreach Team did not fully question how he described his sexuality. Since that time the team follows guidance from the Diversity Trust around asking questions about equalities at the start of an assessment, where appropriate, in order to fully monitor equality and diversity and to make clients feel comfortable to disclose equality information and to make them aware that these needs are considered. Michael did not disclose any further information regarding his previous relationships or any historical domestic violence or abuse.

14.21.4. The Review Panel acknowledges that the procedures in place at the time of Michael's assessment have been changed to reflect the recommendations made by the Diversity Trust.

14.22. Salvation Army

14.22.1. The Salvation Army records indicate that Michael moved into one of their hostels in Bristol on 1st November 2012 and shortly afterwards asked for a referral to the Bridge Rehabilitation Centre which has since closed.

14.22.2. Michael moved into the Bridge on 20th November 2012 and having reported that from the age of 17, he had a history of heroin, benzodiazepines and alcohol usage; he was referred to substitute prescribing. At first he appeared motivated to achieve abstinence but later received several warnings for non-engagement with the programme and non-payment of his service charge resulting in his eviction on 19th February 2013. He moved back into the Salvation Army hostel and stayed there until 8th April 2013.

14.22.3. The Panel is satisfied that the Salvation Army and Bridge Rehabilitation Programme provided Michael with timely support in accordance with their set policies. The Salvation Army has no lessons to learn or recommendations to make in relation to their contacts with Michael.

14.23. Sirona Care and Health

14.23.1. Sirona Care and Health provides the health care services at the Minor Injuries Unit.

14.23.2. On 16th February 2015 Michael attended with an injury to his hand. An x-ray confirmed a fracture and he was treated and referred to the North Bristol NHS Trust trauma clinic. The cause of the injury according to Michael was that he had hit a wall with his hand. He was noted as taking the following medication: methadone and mirtazapine.

14.23.3. On 20th February 2015 Daniel attended the Unit with a minor injury to the index finger of his left hand. An x-ray showed a small foreign body, a piece of porcelain, and the wound was cleaned and dressed. The cause of the injury to Daniel's finger is less clear as the notes do not indicate whether he was asked to explain what caused it.

14.23.4. The IMR author pointed out that it is difficult to say whether either of these injuries related to or might have suggested one or more incidents of domestic violence, but he felt that if their common address had been noted there may have been some cause for suspicion that the two men had a violent or, at least, chaotic lifestyle. The discharge letter sent to the GP included the phrase 'No safeguarding concerns'.

14.23.5. The Panel acknowledges that while the fact that both Michael and Daniel went to the Minor injuries Unit within four days of each other with hand injuries may have indicated some sort of violent behaviour, this is a busy Unit and it is not surprising that their common address did not trigger further questions relating to the cause of the injuries. The Panel supports the views of the IMR author and accepts the lessons learnt and recommendations made as being wholly appropriate.

14.24. Solon South West Housing Association Limited

14.24.1. Michael commenced a tenancy on 1st April 2013 under the "Rough Sleepers Initiative" whereby he was given an assured short term tenancy for a maximum of two years with weekly tenancy support. After Michael moved into his new flat, he went for long periods of time not engaging with the support service. There were complaints from neighbours around his drug use and behaviour. On one occasion the Fire and Rescue Service attended a fire at his flat. After Michael failed to respond to visits, letters and warnings from both Solon and Places for People, an order for possession was given on 14th November 2014. At that time he owed £1950 in rent arrears. On 19th January 2015 a Court bailiff attended at the flat to change the locks and it was then apparent that Michael had already abandoned the property, although large number of used needles and syringes were left at the premises.

14.24.2. The Solon report author was of the opinion that personnel had gone beyond the requirements of the tenancy agreement to try and engage with Michael and every effort was made to provide him with support through Places for People. She concluded that there were no lessons to learn or meaningful recommendations to make.

14.24.3. The Panel is satisfied that Michael was provided with accommodation expeditiously and that numerous attempts were made to engage him with support services.

14.25. South Gloucestershire Clinical Commissioning Group

14.25.1. The IMR author has carefully analysed GP involvement with Michael. She has highlighted that Primary Care provides a universal service and so the organisational involvement for any individual registered with an NHS GP practice is a matter of course.

14.25.2. An individual who is receiving medical care in relation to drug addiction and substitute management would on average, be seen far more frequently than other individuals of the same age. The records of Michael by and large would not stand out from many records of individuals who are treated on shared care drug programmes locally, in that they show evidence of frequent attendances at the surgery to see GPs and drug support workers and a disordered lifestyle. For example non-attendance for supervised consumption, additional prescriptions needing to be supplied, illegal drug usage on top of prescribed medication and difficulty engaging with the routine of service delivery by the organisation (in Michael's case the use of emergency/duty doctor appointments rather that routine bookable appointments).

14.25.3. The GP record evidenced that although Michael saw 18 different GPs over the course of 20 months there was a remarkable consistency of approach from all 18 GPs in trying to encourage him to use the routine booked appointment route in order to ensure continuity of care by one or two GPs; whilst addressing his immediate needs relating to his substance misuse. GPs repeatedly recorded trying to get Michael to book into normal surgery times with the same one or two doctors to enable continuity of care but he continued to use open access/duty doctor appointments which are shorter and therefore not so suitable for review of complex ongoing problems or continuity of care which the GP Practice promoted strongly for all patients. There was a consistently firm and clear approach about the rules involved in prescribing controlled drugs and the need for Michael to be seen at appropriate intervals and by and large this did ensure good attendance especially whilst Michael was on the waiting list for additional drug service support. On one of very few occasions when Michael did attend a routine GP appointment, at a time when he required medical evidence in

support of a housing application, there is evidence that a more detailed history and discussion about his previous medical and specifically psychiatric history was noted. For an individual, such as Michael, with a chaotic lifestyle, using a routine booking system to ensure regular appointments with one or two GPs can present challenges as it appears it did for Michael. At the GP Practice this difficulty was mitigated by the ready availability of access to the emergency/duty doctor slots so that Michael was able to access care but not the continuity which might have supported a better understanding of his mental health needs and possibly a recognition of the abuse which appeared to have been a factor of at least one of Michael's relationships. It is likely that if Michael had not been able to see the GPs at this practice, in the manner he did, he may have disengaged from their service and would have been exposed to greater risk of harm.

14.25.4. The Care Quality Commission requires GP practices to have regard to meeting the needs of, among others, people in vulnerable circumstances who may have poor access to primary care. The IMR author believed that Michael fell into this category. Further, that the GP Practice did strive to meet his needs as well as they were able. But in light of the evidence of domestic abuse experienced by him, an increased awareness of the known association between experience of domestic abuse, either as perpetrator or victim with mental health problems as well as substance misuse might have been of benefit to Michael.

14.25.5. The IMR author saw no evidence in the records, that the BDP practitioner shared the information about Michael's disclosure about domestic abuse and his request for support in seeking help from the men's Crisis Centre, verbally with a GP, although it was properly recorded in Michael's medical record. However individual patient records are reviewed at times of encounters, including consultations and receipt of letters etc, otherwise it is unlikely that the patient's record will be accessed and notes read. This is particularly true in the case of a large practice such as Michael's GP Practice which has over 16,000 registered patients.

14.25.6. In the absence of access to medical information relating to Michael prior to his registration with the GP Practice it is not possible to comment with any certainty about causative or contributory factors. However reasonable conjecture would be that Michael's homelessness and substance misuse made him vulnerable to experiencing abuse, potentially both as victim and perpetrator.

14.25.7. The Review Panel thanks the IMR author for her comprehensive and open review. It acknowledges that whilst BDP did share information, regarding Michael's disclosures of abuse, on his medical record; Michael's GP would have had no reason to access his record, as by that time Michael had stopped attending the Practice. The Panel also recognises that Michael's GP in ██████ was not able to forward Michael's Irish medical records without Michael's consent (which was not given); without sight of those records, the GP Practice in Bristol was relying on the limited information provided by Michael. The Panel is satisfied that all of the lessons learnt will be fully addressed by the recommendations made by the CCG. In addition the Review Panel has asked that GP domestic abuse training, which is currently limited to the IRIS programme (Identification and Referral to Improve Safety) is reviewed to ensure that GPs are equipped to recognise that males including those in same-sex relationships may be victims of domestic abuse.

14.26. South Gloucestershire Council Children, Adults and Health's Adult Services.

14.26.1. The IMR author noted that although the police submitted the report regarding Michael's vulnerability on 12th May 2015, there was no telephone number included. It was not until 20th May 2015, after it was established that the police did not have a telephone number for Michael, that a letter was sent to him and it was not until the 22nd May 2015 that a social worker first spoke to Michael. She offered him an appointment the same day which he declined. He assured her that he was able to leave his home situation if he wanted and an appointment was eventually agreed for 26th May 2015. Whilst an internal risk assessment was completed, the IMR author was nevertheless of a view that the delays in contacting and meeting with Michael were regrettable.

14.26.2. The Panel agreed with the IMR author's conclusions and identified lessons learnt but asked that the use of the internal risk assessment rather than a DASH risk assessment be reconsidered. They are satisfied that this along with the other lessons have now been addressed in the recommendations made.

14.27. South Gloucestershire Multi Agency Risk Assessment Conference (MARAC)

14.27.1. The MARAC Chair in response to a Memorandum of Agreement from the Review, provided a report confirming that on 11th May 2015 the MARAC received a referral from Avon and Somerset Constabulary regarding Michael. Details of the incident triggering the referral are covered in the Police IMR and are set out in section 12 of this report. Prior to the MARAC the Lighthouse team had sent Michael a text message that detailed the support option of Mankind. (The Panel discussed that this was not the safest method of communicating to a victim who is still living with a perpetrator unless this has been agreed by the victim beforehand.) When Michael's situation was discussed at the MARAC meeting on 21st May 2015 the actions agreed were:

- Police to liaise with imbedded intelligence about possible action.
- Police to conduct a welfare check and look to gather more detail on the current circumstances and who else is at the premises. Police to then liaise with adult safeguarding re: strategy discussion and possible ISVA support and to link with DHI for harm reduction support.
- MARAC to also check if Bristol MARAC had any record of the case.

14.27.2. The Review Panel thanks the MARAC Chair for taking the opportunity of this Review to consider all aspects of the MARAC procedures including the need to introduce feedback on agreed actions and to ensure there is appropriate cross border information sharing. The Review Panel is satisfied that the actions to be taken will address the identified lessons learnt.

14.28. South Western Ambulance Service NHS Foundation Trust

14.28.1. On 24th May 2015 the Ambulance service received a call from Daniel which was almost immediately cut off. When the operator called back they were advised the call had been a mistake and that they did not need an ambulance.

14.28.2. The only other contact with the Service was on the 27th May 2015 when a paramedic went to the motorway service station in response to a call that a male was acting

strangely with blood on his T-shirt. Whilst on route, an update was received that the police were on the scene and they were doing CPR as the patient (Michael) had gone into cardiac arrest. A double crewed ambulance arrived at the scene immediately after the paramedic. They tried to resuscitate Michael with ALS, with cannulation, intraosseous access and drug therapy (adrenaline, narcan and advanced resuscitation drugs which were provided by a doctor who arrived in the Wiltshire air ambulance). After a prolonged effort with no response from Michael the Doctor stopped the resuscitation and verified death at the scene.

14.28.3. The Review Panel is satisfied that the Ambulance Service response was in accordance with established practice and that the ambulance personnel did all in their power to resuscitate Michael.

14.29. Wiltshire Police

14.29.1. Wiltshire Police involvement with Michael and Daniel related to the one occasion when they were called to the motorway service station on the 27th May 2015. Officers initially rendered first aid to Michael then assisted the ambulance personnel in giving resuscitation. Michael's death was treated as a non-suspicious drug related death and a file was submitted to the Coroner. Michael had been seen on the service station's CCTV system, going to the toilets on his own and coming out on his own some twenty minutes later. The coroner was satisfied that Michael had self-injected heroin whilst in the toilet. There was no evidence to indicate anyone else was involved in the administration of drugs to Michael.

14.29.2. The Review Panel is satisfied that the officers who attended on 27th May 2015 did their best to resuscitate him and dealt with the incident in line with Force procedures in relation to investigating drug related deaths.

14.30. Pathologist's Report

14.30.1. The post mortem examination found the cause of Michael's death to be unnatural, being drug toxicity. The toxicology tests showed significant concentration of morphine in his blood and urine. The additional presence of certain metabolites in the post mortem blood suggested the use of illicit heroin rather than morphine, although additional morphine use could not be ruled out. The major risk to life resulting from heroin use is in its depressant effect on the central nervous system, notably causing respiratory depression. The additional presence of methadone may have exacerbated any toxicity arising from heroin use.

15.1. Effective Practice/Lessons to be learnt

15.2. The following agencies that had contacts with Michael and Daniel have identified effective practice or lessons they have learnt during the Review.

15.3. Avon & Somerset Constabulary

15.3.1. Throughout their dealings with Michael and Daniel, officers of the Avon and Somerset Constabulary demonstrated effective practice in accordance with their Procedural Guidance on Domestic Abuse. Greater awareness may need to be developed amongst Lighthouse staff to ensure that in unusual/less frequently occurring cases peer/supervisory reviews may assist in ensuring that the best support/referrals are made. There is a case for a review of the services available in both the public and charitable sector to ensure that individuals in Michael's situation (as a male sex worker and victim of domestic abuse within a same-sex relationship) receive appropriate and helpful referrals. This case has highlighted a potential gap in services for individuals with Michael's particular vulnerabilities.

15.4. Avon and Wiltshire Mental Health Partnership NHS Trust

15.4.1. Historically, there was a need for improved communication, particularly with primary care. This has subsequently been addressed through the introduction of shared consent across the ROADS treatment system and shared electronic records (Theseus).

15.4.2. It appears that Michael as the service user was at risk of exploitation due to his young age and involvement as a male sex worker, which would likely be with older men, potentially funding his substance use. More inquisitive questioning about the nature of the relationship with his partner and the funding of his drug use may have highlighted potential risks in these areas.

15.4.3. More assertive ways of managing the transfer of service users from BDP into BSDAS needs to be explored.

15.5. Bristol Drugs Project

15.5.1. Reducing Risk of Drug-Related Death

Michael's death occurred during a period that saw a marked increase in overdoses, both fatal and non-fatal. All ROADS staff were aware of this phenomenon, and the feedback regarding variations (generally upwards) in the purity of drug supplies locally, from data compiled by Avon and Somerset Police from locally seized samples. Information is routinely shared with clients and at this time the heightened focus would have seen Michael being informed of the increased risk of overdose. Good practice around Michael's needs was demonstrable with regards work to help him reduce the risks associated with his ongoing injecting of heroin. He was able to access testing to ascertain his Blood Borne Virus (BBV) status, and had completed a course of vaccinations to protect himself from Hepatitis B. At the time of giving Michael the results of his BBV tests his Shared Care worker had discussed future BBV testing with him in a further three months, recognising continuation of risk behaviours.

15.5.2. Actions Taken to Promote Retention in Opioid Substitution Treatment (OST)

Efforts to keep Michael engaged and in receipt of OST when he had to change GP surgery, though ultimately unsuccessful, were proactive attempts to reduce the likelihood of Michael exiting treatment and losing its evidenced protective effects. Bristol's Operational Guidance was adhered to, and efforts made to make re-engagement as easy and timely as possible for Michael. For example, multiple possible appointment slots were actually reserved for Michael at a new GP Surgery after his contact with BDP on 26th May 2015 when he informed BDP of his intention to complete his registration at that GP surgery that day.

15.5.3. Recognition of Controlling Behaviours

Michael's regular Shared Care worker recognised what she believed to be controlling behaviour from his new partner (Daniel), and appropriately sought to explore her concerns with Michael immediately on his own, to be able to offer advice and support should he need this.

15.5.4. Lessons Learned re Domestic Abuse

Although the controlling behaviour and the later knowledge that Michael and Daniel's relationship had been violent, there are questions as to whether practice was as effective as it ought to have been in responding to this information. A gap in communication has been recognised, between BDP's Shared Care team and the Engagement Team (who staff the Direct Access and needle exchange service). There was no direct communication around the issues raised regarding Domestic Violence, where clearly knowledge would have informed supportive and appropriate intervention. It is not impossible that those working in the NSP would access a client's electronic treatment record, but it should not be assumed and is unlikely to be routine because NSP records are recorded on a separate and standalone part of the system. This separation exists to ensure that those using the NSP have the protection of knowing that their use of the service is confidential. Consideration for client confidentiality does not however, prevent proper information sharing where this would be in a client's interest or reduce risk in any area.

15.5.5. Two further issues were recognised by BDP. The first being whether there should have been a referral to MARAC. BDP acknowledges that Michael's vulnerability was not fully appreciated. This was possibly because he normally presented with a quite brash exterior and was experienced as a demanding client at times. Also it is possible that as a male in a same-sex relationship he may have not been considered as vulnerable as a woman in similar circumstances.

15.5.6. Secondly BDP has considered whether they might have been more proactive in pursuing a referral to appropriate services when Michael told of his desire to leave Daniel. His desire to seek a placement with mental health-related support was responded to by being advised how to self-refer, but nothing more assertive. Again an under-estimation of Michael's vulnerability may have informed the decision to accept his failure to self-refer and ultimately to apparently change his mind without further questioning.

15.6. Developing Health and Independence

15.6.1. DHI identified the need to establish defined timescales between triage and full assessment.

15.6.2. DHI recognises the need to review triage paperwork to ensure immediate risks are identified at an early stage

15.6.3. DHI needs to ensure that the appropriate level of assessment (including risk) takes place for all clients triaged and accepted into support services and that this should be completed prior to or in parallel with support being offered.

15.7. North Bristol NHS Trust

15.7.1. North Bristol NHS Trust staff acted in line with the Trust Policy on Domestic Abuse and Violence with regard to screening. Michael was not a member of a high risk group and the injuries were consistent with the explanation given by Michael.

15.7.2. The information held by the Trust although limited was not shared at MARAC as it should have been.

15.8. St. Mungos Broadway

15.8.1. The Outreach Team has, since their contact with Michael been fully assessing equalities data at the start of the assessment process to accurately record diversity issues and to offer appropriate support to homeless people. However this was introduced separately to this Review as part of improving equalities monitoring.

15.9. Sirona Care and Health

15.9.1. The phrase 'No safeguarding concerns' appeared in the letter to Michael's GP (relating to his injured hand) and in the circumstances it is felt this was not a helpful phrase to include as it might have suggested that this possibility had been thoroughly checked out and discounted. The reason for this was the electronic record for Michael stated "No safeguarding concerns were indicated at the time" but this was automatically translated in the discharge letter into a much more categorical statement "No safeguarding concerns" which could be unintentionally misleading.

15.10. South Gloucestershire Clinical Commissioning Group

15.10.1. Effective practice: The consistent approach by all GPs to working with a patient who was affected by substance misuse mitigated to a certain extent the fact that 18 GPs saw Michael over the course of 20 months. There is evidence of good two-way communication between a number of GPs, BDP practitioners and pharmacies and this ensured a significant degree of safety around drug misuse for Michael.

15.10.2. Lessons learnt: The possibility of Michael being affected by domestic abuse does not appear to have been explored by the GPs who saw him. Given the evidence of the supportive nature of the care provided by all 18 GPs there is a need to raise awareness of male victims of

domestic abuse to better improve recognition of this as a risk and to enable provision of support to reduce risk of harm

15.10.3. In Bristol and South Gloucestershire there is training available to all GP practices around domestic abuse in women, through the IRIS (Increased Recognition to Improve Safety) programme. In the training, mention is made about male victims and perpetrators and information on signposting is included in a care pathway for victims of domestic abuse, however in light of this Review that training about male victims should be enhanced. IRIS has only been validated as a tool for use in primary care in relation to domestic abuse in women.

15.11. South Gloucestershire Council Children Adults and Health's Adult Services.

15.11.1. In view of the time lapse from the date of notification by the Police to the scheduled first meeting between Adult Services and Michael, work needs to be done about time scales.

15.11.2. There was a significant delay of days before the Access team Senior Practitioner was able to speak to the police officer involved as he was not on duty. His Sergeant or another senior officer in the police could have been contacted.

15.12. South Gloucestershire MARAC

15.12.1. Reviewing the MARAC process raises questions about whether there is enough time between the deadline for MARAC referrals and the circulation of the agenda. Gathering of additional information, useful to other MARAC agencies, is compromised by current time constraints.

15.12.2. Given the referral was made on the basis of professional judgement it would be useful to know who completed the risk assessment.

15.12.3. Although the referral form contained a summary of information from the Police National Computer (PNC) in relation to Michael and Daniel's previous police contacts, this had not been analysed by the referrer to provide an opinion on how the information affected the risk.

15.12.4. There were missed opportunities to speak to Michael prior to the MARAC, which compromised the ability of MARAC to consider his wishes and needs. Safety Planning is also more likely to be successful with an actively engaged victim.

15.12.5**.** Efforts should be made to clarify and improve the implementation and documentation of safety measures by all agencies throughout the MARAC process.

15.12.6. By not having Bristol agencies participating in this South Gloucestershire MARAC, there were missed opportunities for information sharing and safeguarding of Michael.

15.12.7. There is a need to ensure that the MARAC meeting minutes accurately reflect all of the discussions held.

16. Conclusions

16.1 In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the Review used the opportunity to review their contacts with Michael and Daniel in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?
- Will the actions they take improve the safety of drug users and domestic abuse victims including those from the Lesbian, Gay, Bisexual and Trans communities in South Gloucestershire and Bristol in the future?
- Were there any links between Michael's death and other drug related deaths in the Bristol and South Gloucestershire areas during 2014/2015**?**
- Was Michael's death predictable?
- Could Michael's death have been prevented?

16.2. **Have the agencies involved in the joint Review used the opportunity to review their contacts with Michael and Daniel in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?**

16.2.1. The Review Panel acknowledges that the Individual Management Reviews and other reports have been thorough, open and questioning from the view point of Michael and Daniel. The Panel is satisfied that several of the organisations have shown that their contacts with either Michael or Daniel were in accordance with their established policies and practice and that they have no lessons to learn. Other organisations have used their participation in the Review to properly identify and address lessons learnt from their contacts with Michael and Daniel in line with the Terms of Reference (ToR).

16.3. **Will the actions they take improve the safety of drug users and domestic abuse victims including those from the Lesbian, Gay, Bisexual and Trans communities in South Gloucestershire and Bristol in the future?**

16.3.1. The Review Panel believes that the agreed recommendations address the needs identified from the lessons learnt. The Panel also recognises that although the agencies represented on the South Gloucestershire Safer and Stronger Community Safety Partnership and Bristol Community Safety Partnership have robust, fit for purpose, domestic abuse policies, some of the other agencies involved in the Review did not have domestic abuse policies. With the assistance of the South Gloucestershire and Bristol Community Safety Partnerships, those agencies are now in the process of addressing this gap. Provided those recommendations, strategies and policies are fully and promptly implemented, they will improve the safety of domestic abuse victims in Bristol and South Gloucestershire in the future. All of the specialist drug services with which Michael had been involved have clear policies on how an individual can access drug treatment services. The Panel wishes to highlight the Bristol Drug Project Needle and Syringe Programme as a proven harm reduction initiative which is also an effective way of sustaining contact with those drug users who may not be ready/willing to enter a treatment programme. The Review Panel believes that the cross agency client database system which has been introduced in Bristol and the one which is being introduced in South Gloucestershire will make a significant improvement in the cross agency care provided to service users.

16.3.2. The Diversity Trust has played a significant part in this Review by drawing attention to the particular problems faced by gay men in relation to domestic abuse, mental health and drug and alcohol abuse. It has used its participation to inform all of the agencies taking part in the Review of the research it has conducted, the partnership work and training it is involved in with regard to both domestic abuse and drug and alcohol misuse.

16.4. Were there any links between Michael's death and other drug related deaths in the Bristol and South Gloucestershire areas during 2014/2015?

16.4.1. The Bristol City Council substance Misuse Team and South Gloucestershire Council Drug and Alcohol Action Team that are responsible for commissioning drug and alcohol services within their respective areas have carried out reviews encompassing the known drug related deaths in Bristol and South Gloucestershire during 2014-2015. It is important to stress that the reviews were only able to consider those deaths notified to them by treatment agencies and the police, it is possible that there are other drug related deaths not known to those organisations. The Coroner has yet to hold an inquest in a number of cases as toxicology reports have not been received defining the causes of death. It is also acknowledged that the cause of death is on occasions stated only in broad terms e.g. multiple organ failure, pneumonia, cardiac arrest etc. Within those limitations, the reviews found no evidence of any connection between the deaths in terms of the source or purity of the drugs or between the individuals themselves, other than the deceased were all known to drug treatment service providers.

16.5. Was Michael's death predictable?

16.5.1 Whilst Michael's life was chaotic it is clear from the evidence provided to the Review that he took steps to reduce the risks.

During the last few weeks of his life he increasingly told the police, his drug worker and social services that he wanted to leave Daniel. Whilst those agencies offered him help and support in accessing new accommodation, as is common with victims of abuse, he was not ready or able to accept this help.

The Review Panel is satisfied that the agencies had no reason to predict his death at that time.

16.6. Could Michael's death have been prevented?

16.6.1. The Review Panel accepted that the drug support agencies Michael sought help from, did encourage him to control his consumption of drugs and alcohol. They engaged him in harm reduction and substitution programmes. Whilst Michael tried on several occasions, he was not able to maintain his commitment to change. This is not uncommon, people trying to control their drug or alcohol consumption often make many attempts before succeeding.

16.6.2. Whilst Michael may have suffered from either depression or anxieties in the past. The Panel acknowledged that his Bristol GP had little opportunity to explore his mental health needs in depth.

16.6.3. This Review has highlighted the mind-set that staff may not consider that a man, including those in same sex relationships, could be a victim of domestic abuse. Nevertheless the Panel accepts that those agencies that Michael told of the domestic abuse he suffered, did offer him tangible help.

16.6.4. The Panel has therefore concluded that whilst there are many lessons to be learnt there was nothing any agency could have done that would have prevented Michael's death.

17. Recommendations & Action plan

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Government Equalities Office	Enhancement or amendment to Equality Act 2010 to ensure consistency of monitoring of protected characteristics and consistency of training.	National	South Gloucestershire Community Safety Partnership write to the GEO.			1st January 2017	
Cross Agency	Where a victim may have links or associations across Local Authority boundaries, that the MARAC and its participating agencies ensure that the MARAC in the relevant adjoining area and organisations in that area are informed and invited to share information.	Cross Agency Avon and Somerset Wide	To be raised at the Avon and Somerset Police's Strategic Violence Against Women and Children Group for discussion and agreement with all Domestic Abuse leads about how MARAC across the Force can establish an appropriate mechanism to share cross border information.	Avon and Somerset Police and all authority areas within the force area.	Avon and Somerset and all authority areas agree a minimum standard for information sharing where it is indicated a victim or perpetrator has lived within another locality.	February 2016	South Gloucestershire Council are in the process of reviewing the MARAC operating Protocol to ensure that it reflects the role and responsibility of the MARAC administrator and MARAC Panel members. Within the operating protocol it will

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
							stipulate that where a referral form indicates that victim or perpetrator has lived in another area that it is the responsibility of the administrator to check the relevant MARAC and the panel member to check their specialism within the area indicated. Furthermore South Gloucestershire are looking to improve the referral form to make it clear within the form whether a victim or perpetrator has lived within another area within the last 12 months.

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Cross Agency	All agencies taking part in this Review and organisations which are members of the South Gloucestershire and Bristol Community Safety Partnerships have role commensurate Equalities training including competencies in working with Lesbian, Gay, Bisexual and Trans communities.	Cross Agency South Gloucestershire and Bristol	South Gloucestershire and Bristol Community Safety Partnerships task their equalities coordinators to review role commensurate Equalities training including competencies in working with Lesbian, Gay, Bisexual and Trans communities; with all partner agencies.	Anti-Social Behaviour and Community Safety Team South Gloucestershire Council	Minimum Standard of training is achieved across all organisations within both CSPs	December 2016	

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Cross Agency	South Gloucestershire and Bristol Community Safety Partnerships will assist those none specialist organisations that do not have appropriate domestic abuse policies to introduce fit for purpose domestic abuse policies.	Cross Agency South Gloucestershire and Bristol	The Community Safety Partnerships will notify partnership organisations and (through Drug and alcohol service commissioners) drug and alcohol commissioned services that they can be provided with support and advice on what should be included within fit for purpose domestic abuse policies.	South Gloucestershire and Bristol Community Safety Partnerships, Women's Aid and individual organisations that currently do not have DA policies		31st March 2016	While those agencies that are incorporated within the Partnerships and those that are commissioned to provide drugs and alcohol services will introduce domestic abuse policies by 31st March 2016. Women's Aid is conducting an ongoing programme to assist private businesses to develop appropriate domestic abuse policies.

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Cross Agency	South Glos and Bristol substance misuse services to ensure communication between treatment providers and pharmacies- with particular focus on information being shared on the initiation and cessation of opiate substitution therapy prescriptions.	Cross Agency South Gloucestershire and Bristol	Commissioners to communicate expectations to commissioned treatment providers	-South Glos DAAT -Bristol Substance Misuse Team	Protocols reviewed to reflect expectations	Completed	
Cross Agency	Commissioners to require agencies successful in tendering for contracts to have effective policies around domestic abuse that recognise issues relating to LGBT community	Cross Agency South Gloucestershire and Bristol	Commissioners to consider agencies efficacy in responding to same-sex domestic abuse when evaluating tender submissions	-South Glos DAAT -Bristol Substance Misuse Team	Evaluation process reflects needs of same-sex relationships	ongoing	

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Avon and Somerset Constabulary	The method of making contact with a vulnerable victim should be considered extremely carefully, particularly if it is known that the perpetrator controls access to/use of a mobile telephone.	Force wide	An exercise to raise awareness of this in the Lighthouse Teams should be undertaken.	Avon and Somerset Constabulary		31st December 2015	
Avon and Somerset Constabulary	Where unusual/less frequently occurring cases requiring support present themselves, Lighthouse staff should be encouraged to seek support by discussing the case with a supervisor before making referrals/deciding upon the method of communicating with the victim.	Force wide	An exercise to raise awareness of this in the Lighthouse Teams should be considered.	Avon and Somerset Constabulary		31st December 2015	

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Avon and Somerset Constabulary	Avon and Somerset Constabulary should seek new partnerships with charities working with men, including men and sex working men who are at risk of exploitation/abuse from their partners, including risk of DA.	Force wide	Creating a Robust and Visible Collaborative Service for Male Victims of Rape and Sexual Assault under the Rape and SSO plan	Avon and Somerset Constabulary	The Terence Higgins Trust are eager to work with Force in this an area of work that is of interest to them and that may be developed. Similarly, Barnardos advise that they work with young males (up to the age of 25) who experience sexual abuse so may be another organisation with whom it would be helpful to develop contacts for the purposes of referrals	3rd December 2016	
Avon and Wiltshire Mental Health Partnership Trust (AWP)	Learning from this incident to be shared with BSDAS teams, particularly in relation to more inquisitive questioning about	local	Staff training to increase awareness of the potential risks relating to male sex work, use of substances and potentially abusive relationships, to	BSDAS		End March 2016	

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
	potential risk issues.		include training in the use of the DASH risk assessment.				
Avon and Wiltshire Mental Health Partnership Trust (AWP)	BDP and BSDAS to review procedures for transferring service users from shared care to BSDAS specialist prescribing, to explore whether there are ways of more effectively facilitating service users attendance and engagement with the new team.	Local	BDP shared care manager and BSDAS Stokes Croft manager to meet to review how the transfer process can be improved to facilitate attendance and engagement between services.	BSDAS	A new collaborative ROADS referral panel is now in place to assess and monitor suitability of new referrals from one element of the treatment system to another. As part of this process, this group will be asked to consider ways of facilitating attendance and engagement in the transfer process.	End November 2015	

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Avon and Wiltshire Mental Health Partnership Trust (AWP)	BSDAS to explore accessing Illy electronic case records for continuity of care purposes for service users attending South Gloucester Drug and Alcohol services.	Local	BSDAS to explore costings, governance and mechanics around transferring from Theseus to Illy.	BSDAS		End March 2016	
Bristol Drugs Project (BDP)	BDP will establish a centralised system of recording where issues pertaining to Domestic Abuse are recognised	Local	Extension of existing arrangements around Vulnerable Adults (VA) under Safeguarding Policy and Procedure. 2. Centralising of response and involvement with MARAC	BDP - responsibility of safeguarding lead.	1. Staff to be advised of extension of VA arrangements to include all cases where DV is noted. 2. Arrangements to be confirmed with Bristol City Council Substance Misuse Team lead.	Agency Meeting 30.11.15 2. Meeting arranged for 09.11.15	
Bristol Drugs Project (BDP)	Training provision to be reviewed in light of lessons learned through DHR process	Local	Existing training to be updated, especially around issues pertaining to DV within same sex relationships.	BDP - responsibility of Managers delivering or arranging training.		June 2016 - Next date for Domestic Abuse training in Internal Programme.	

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Bristol Drugs Project (BDP)	Integration of DASH risk assessment tool into practice where DV is highlighted	Local	Staff to be familiarised with form and process to use same	BDP - responsibility of safeguarding lead.		1. Agency Meeting 30.11.15	
Developing Health and Independence (DHI)	Triage risk assessment tool to be reviewed and revised	Local	Draft new tool and consult with team leader and staff	DHI	Revised risk assessment tool drafted, revised risk assessment tool agreed, revised risk assessment tool adopted	Revision complete by and agreed 30/11/2015. Implemented by 31/12/2015.	
Developing Health and Independence (DHI)	Workflow timescales between triage and assessment to be established	Local	Draft workflow timescales and consult with team leader and staff	DHI	Timescales drafted, timescales agreed, timescales adopted	1st January 2017	
Developing Health and Independence (DHI)	Cross organisational information sharing. Implement a new working model for information sharing across and within the organisation, to include a single	Regional	Review of all local MARAC/safeguarding information sharing arrangements. 2. 'Test' new model from January to March 2016. 3. Implement fully from April 2016.	DHI	Protocol drafted, protocol agreed, protocol adopted	Fully implemented from April 2016.	On the agenda for November 2015 executive meeting

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
	point of reference for all client record databases held by the organisation.						
Developing Health and Independence (DHI)	Undertake a 'lessons' learnt meeting with the team in relation to this case, to include the lessons learnt above, plus potential assumptions about risk, boundaries of role in supporting client in relation to person in treatment i.e. where they are not directly working with the person in treatment	Local	Put on agenda for Family & Carers Service Team Meeting	DHI	Meeting takes place, minutes of meeting circulated, any agreed practice learning is embedded	Nov-15	
Developing Health and Independence (DHI)	Domestic Abuse - develop a specific policy	Regional	Draft policy to be reviewed and approved by DHI's Executive team	DHI	Policy drafted. Policy approved by executive team. Policy implemented.	Drafted by end January 2016, approved by end February 2016, implemented by end March 2016.	Currently, Domestic Abuse is covered within DHI's Safeguarding Adults policy. Domestic Abuse training is part of the organisation's core training

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
							programme and services are actively involved in MARAC. DHI also delivers services for perpetrators of Domestic Abuse.
Developing Health and Independence (DHI)	Ensure team and the service are culturally competent.	Regional		DHI		Fully implemented from April 2016.	Existing mechanisms: the service has an Equality & Diversity Champion, staff have attended Diversity Trust training (commissioned by Safer Bristol), DHI contributed to a Bristol ROADS wide multi-agency Equalities & Diversity working group (which focuses on LGBTQ community).

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
							DHI has an Equality & Diversity policy, which was reviewed by Diversity Trust in 2014. Earlier in 2015, the service undertook an equality impact assessment.
North Bristol NHS Trust	Safeguarding training to be reviewed to include reinforcement that DA can and does occur in same sex partnerships	local	Safeguarding Lead to organise.	North Bristol NHS Trust		31st March 2016	
North Bristol NHS Trust	Information sharing at MARAC to be audited to ensure information is shared when it is in the possession of NBT	Local	MARAC reps to be informed	North Bristol NHS Trust		Jan-16	
St. Mungo's Broadway	Amend initial assessment forms to assess equality and diversity needs	Local	Ensure equality and diversity questions are captured at the start of an assessment form.	St Mungos Broadway / Diversity Trust	When clients first enter a service they feel confident that the	Completed.	St Mungos Broadway Street Population Outreach Team

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
	at the start of the assessment process when a client first enters the service. As required using guidance from the Diversity Trust.				service is fully aware of equality and diversity issues and have an open opportunity to disclose and discuss individual needs related to diversity. The service is then able to fully address these needs and provide appropriate support to meet them. Staff have more awareness of equality and diversity needs and are able to signpost to specialist support agencies where appropriate. Improved monitoring of equality and diversity issues is accurately recorded.		implemented this action in 2014 using advice and guidance from the Diversity Trust.

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
Sirona Care and Health	Sirona managers responsible for the MIU to provide additional training for staff to ensure that the full checklist of safeguarding questions (including questions about mental health) are completed in every case.	Local		MIU Managers		31st March 2016	
Sirona Care and Health	The Safeguarding Lead for Sirona to meet with MIU staff as a matter of urgency and provide additional bespoke training on safeguarding and domestic violence issues.	local	Training to be organised	Safeguarding Lead for Sirona		30 November 2015	Complete.
South Gloucestershire Council: Children, Adults and Health	To discuss the outcomes of this report with all Senior Practitioners.	Local	Meeting to ensure timescales are adhered to.	South Gloucestershire Council - Access Team	To facilitate improved practice and performance for the future	9th December Business Meeting	To be completed 9th Dec and principles of good practice to be embedded

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
South Gloucestershire Council: Children, Adults and Health	To ensure all correspondence from MARAC is copied to Senior Practitioners.	Local	Correspondence to be shared	South Gloucestershire Council - Access Team	Achieved to be integral to ongoing practice	21st October	21st October achieved to be part of ongoing standards
South Gloucestershire Council: Children, Adults and Health	To ensure that any post relating to possible risk is sent 1st class.	Local	To be shared with Access Team.	South Gloucestershire Council - Access Team	In progress	4th November Team Meeting	From 4th November to be part of ongoing good practice
South Gloucestershire Council: Children, Adults and Health	To devise scripts when contacting Service User by phone who may have an abuser present.	Local	Scripts to be devised with Senior Practitioners and Team Manager.	South Gloucestershire Council - Access Team	To be part of ongoing improved practice	9th December Business Meeting	9th December onwards , to be made integral to good standard practice
South Gloucestershire Council: Children, Adults and Health	To ensure that all cases with potential domestic abuse are prioritised and utilising the DASH risk assessment where appropriate within adult safeguarding.	Local	Decisions to be made in a timely way.	South Gloucestershire Council - Access Team	To be part of ongoing improved practice	9th December Business Meeting	For ongoing practice and review

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
South Gloucestershire Council: Children, Adults and Health	Ensure all recommendations are followed and reviewed regularly in Supervisions	Local	Team Manager to discuss in Supervisions with Sen Prac/Serv Man	South Gloucestershire Council - Access Team	In progress to be reiterated in Team Meetings and supervisions	21st October	For ongoing improved practice , subject to review
South Gloucestershire Council: Children, Adults and Health	Contact with named police officers and discussion with alternative colleagues when not available	Local	Team Manager and seniors to discuss with alternative police personnel when officers not on shift	South Gloucestershire Council - Access Team	Embed as good practice rather than matters being delayed	4th November Team Meeting	4th November onwards , to be made integral to good standard practice in the Access team
South Gloucestershire Council: Children, Adults and Health	Building on DASH risk assessment completed by other agencies to ensure a more comprehensive assessment of risk and consistent approach	Local	Managers to discuss in Team Meetings and group supervisions	South Gloucestershire Council - Access Team	Ensure that team members build on DASH that may be in existence to complete work and fine tune rather than starting again to ensure consistency	4th November Team Meeting	4th November onwards , to be made integral to good consistent multi agency work .Subject to review
South Gloucestershire Council: Children, Adults and Health	Adherence to agreed time scales for actions and feedback, avoidance of drift	Local	Team Manager , Seniors and all Access staff to set time deadlines on actions	South Gloucestershire Council - Access Team	Facilitate improved practice and resilient timely standard setting that is measurable	9th December Business Meeting	9th December onwards , to be made integral to good standard practice

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
South Gloucestershire MARAC	The MARAC Operating Protocol should be reviewed to ensure it is fit for purpose and ensure confidence that it is a process not a meeting.	Local	A process for contacting 'hard to reach' victims prior to a MARAC (to check welfare, seek consent for / make them aware of the referral and to request information about their wishes) § Best practice in terms of safe phone contact with victims (e.g for those who have stated their phone is monitored by the perpetrator, or for those in same sex relationships where it is likely to be difficult to confirm the person you are speaking to).	MARAC Steering Group		March 2016	
		Local	The MARAC Steering Group should review the standing invite list for MARAC on a quarterly basis for accuracy and appropriateness. In addition, a process should be agreed in terms of responsibility for identifying and	MARAC Steering Group		March 2016	

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
			including additional agencies in any MARAC case				
		Local	The MARAC Steering Group should review best practice in terms of MARAC Minutes and make any necessary amendments to the South Gloucestershire process / template as required.	MARAC Steering Group		March 2016	
		Local	Increase the time between the referral deadline and circulation of the MARAC agenda to allow time to seek further information and identify additional agencies to attend. E.g. In the case of Michael – an appropriate method of contact for him and liaison with relevant Bristol agencies.	MARAC Steering Group		March 2016	

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
South Gloucestershire MARAC	The MARAC Referral Form should be reviewed to ensure it is fit for purpose and reflects best practice.	Local	Task and Finish group to convene to discuss and amend the referral form; sign off from PADA to be received.	MARAC Steering Group		March 2016	
South Gloucestershire MARAC	The MARAC Steering Group to consider implementing appropriate quality assurance and audit functions	Local	Task and Finish Group to look at best practice for quality assurance processes.	MARAC Steering Group		March 2016	
South Gloucestershire Clinical Commissioning Group (CCG)	Practices to be encouraged to consider implementing a system of identifying and allocating known drug users to a specific GP who should co-ordinate their care, with flagging of records to indicate which GP they should be directed to.	Local	Presentation of DHR learning/findings to CCG Membership Meetings, Safeguarding Lead GP meetings and Practice Manager Forums.	Primary Care	GP practices will have an enhanced understanding of the benefits of continuity of care for vulnerable patients.	March 2016 - to fit with meeting agenda schedules	

Agency	Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and Outcome
South Gloucestershire Clinical Commissioning Group (CCG)	Awareness raising and training about the links between mental health and substance misuse and domestic abuse to be reinforced.	Local	Incorporation of DHR findings to be included in Safeguarding Training for GPs	Primary Care	GPs will have a better understanding of indicators of domestic abuse and a lower threshold for seeking disclosure to allow support to be offered	Sept 2016 - to allow time to incorporate into training programmes	
South Gloucestershire Clinical Commissioning Group (CCG)	Training in recognition of domestic abuse in men to be made available to all GPs.	Local	Incorporation of DHR findings to be included in Safeguarding Training for GPs	Primary Care	GPs will have a better understanding of domestic abuse in men and a lower threshold for seeking disclosure to allow support to be offered	Sept 2016 - to allow time to incorporate into training programmes	

Appendix A: Glossary of Terms

Avon and Somerset Constabulary

- **PNC (Police National Computer)** – Contains information of convictions, remand history and court appearances of identified individuals.

- **PND (Police National Database, previously Impact Nominal Index)** – a national Police computer system which allows officers to establish, in seconds, whether any police force anywhere else in the country holds relevant information on someone they are investigating. Previously, this information would not have been visible outside the force holding the record and was implemented following the Soham enquiry.

- **ASSIST** – a "data warehouse" search tool used with Avon and Somerset Constabulary that trawls all other Avon and Somerset systems for information on individuals in relation to road traffic collisions, liquor licensing, firearms, calls for service from the public and details of crimes reported to the Police.

- **WEBSTORM** – The command and control system used by Avon and Somerset Constabulary to manage calls for service. Whenever a public contact requiring police action is received a 'log' is created at the first point of telephone contact with the Police and attendance is managed by control room staff based in Police Headquarters. If the call results in the police recording details of a criminal offence or a crime related incident the STORM log will be concluded with a Guardian reference number for the incident.

- **Guardian** – This is a crime and intelligence management system and was implemented in 2007. All criminal offences and crime related incidents will be recorded here, including all domestic abuse cases regardless of whether a crime or verbal argument is reported. The system enables information relating to domestic abuse, child abuse and missing persons to be linked to a nominal record. Information which is not reporting a specific incident will be recorded as "intelligence" – this would include information obtained from a third party, via Crime Stoppers or shared by another agency. Risk assessments use the national DASH questionnaire and are collated in one section, remain dynamic and linked to the individuals involved. These are available at all times to all staff and ensure a complete history can be viewed in one place.

- **CMU** – Prior to the implementation of Guardian in 2007 domestic abuse incidents were recorded on a paper based CMU system which was then managed using electronic tracking software.

- **NSPIS** – a record of every person arrested by Avon and Somerset Constabulary. This not only records the fact of their arrest but also records every aspect of their treatment and detention whilst in police custody. This is a legal requirement under the Police and Criminal Evidence Act 1984.

- **BLUESTONE -** Operation Bluestone was formed in September 2009 to tackle rape and sexual assault in the City of Bristol. This dedicated team secured dedicated resources to provide a comprehensive service to victims and provided an improved capability in identifying unknown suspects and locating further evidence. The team is now incorporated (since October 2014) into **PROTECT** (see below) and is responsible for all victim-based contact, offering each victim-tailored support and advice with the support of partner agents including the Bridge.

- **CAIT -** Child abuse investigation teams – Prior to March 2012 this team solely collated and investigated child safeguarding cases.

- **DAIT** - Domestic abuse investigation team- Prior to March 2012 this team solely collated and investigated domestic violence incidents.

- **SAIT –** Sexual abuse investigation teams - Prior to March 2012 this team solely collated and investigated sexual violence incidents.

- **PROTECT –**Following a Force re-organisation in October 2014, the investigations department consists of multi-skilled investigation teams based in each of the three Policing Areas, whose focus is on the most vulnerable victims and the riskiest of offenders.

Teams are equipped to carry out proactive and reactive investigations into all types of serious and complex crime. We also have the Investigation Policy, Strategy and Support Team which includes the Source Handling Unit, Covert Authorities Team and a Major Crime Review Team.

Investigators on the Investigation Teams are made up of investigators with specialist skills around three investigative areas of Solve, Protect and Convict.

Solve investigators have specialist skills around high risk and complex, both reactive (crime in action) and proactive (organised crime), investigations.

Solve also includes the Economic Crime Team and Financial Investigators working within the three Policing Areas.

Protect investigators have specialist skills in the investigation of incidents vulnerable victims such as Child abuse, Domestic Abuse and Rape.

The Bluestone ethos is embedded within the Investigation Team, the SAIT role has been expanded and additional Investigators are being trained to perform the role force wide. Convict investigators have specialist skills in the investigation of offences linked to IMPACT offenders – those individuals who commit the most crime.

Investigation teams are available for help and advice 24 hours a day seven days a week.

- **DASH** - implemented in 2009- Avon and Somerset Constabulary are currently using this national risk assessment model for cases of domestic abuse. This is a common model used by the police and partner agencies. DASH is an acronym for Domestic Abuse Harassment and Stalking and includes honour based violence and forced marriage. DASH was implemented throughout the Force by a rolling programme over a year between March 2010 and March 2011. Prior to this the risk assessment model was called SPECCS, an acronym for Separation, Pregnancy, Escalation, Child custody, Cultural issues, Stalking and Sexual Assault. It was conducted on a largely paper based system with additional tracking through electronic software.

- **Intelligence reports -** Information is recorded as intelligence using the national standard for coding material. It ensures standardisation whilst protecting the source of the

intelligence, and is a method to identify risks, and evaluate the source of the information, its provenance and the manner in which it is disseminated. Following this standard ensures that information held is for a policing purpose and in accordance with the law. Guardian is the Force system for recording all intelligence. It is assessed and entered on to Guardian by trained staff who check the report for accuracy and will sanitise reports if necessary to protect the source of the information as and when required.

- Police intelligence comes from a variety of sources. It can be from an “open” source which is available to a member of the public (e.g. material available on the internet); it can be from a closed source where there is no risk in identifying the source (e.g. minutes from a Child Protection Case Conference, or police officers attending at an address); or it can be from a sensitive source. Sensitive sources include information from people who talk to the police with an expectation of confidentiality, obtained by technical means, obtained from covert police activity or information obtained from other law enforcement or security agencies.

Bristol Drug Project:

TITRATION: a method or process of determining the concentration of a dissolved substance in terms of the smallest amount of reagent of known concentration required to bring about a given effect in reaction with a known volume of the test solution**.**

South Gloucestershire Clinical Commissioning Group (CCG):

IRIS (Identification and Referral to Improve Safety):
IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It is aimed at women who are experiencing DVA from a current partner, ex-partner or adult family member.

Appendix B: Bibliography

Avon and Somerset Constabulary Lighthouse Victim and Care Initiative

Avon and Somerset Constabulary Victims Code of Practice.

CAADA Responding to Domestic Abuse: Guidance for General Practice.

Domestic Homicide Review Toolkit.

Domestic Violence, Crime and Victims Act 2004.

Drug Related Deaths: Setting Up a Local Review Process.

Equalities Act 2010

Good Medical Practice 2013

Guidance to doctors & GPs on the release of medical records into a Domestic Homicide Review. Sheffield Safer & Sustainable Community Partnership.

HM Government Information Sharing: Guidance for practitioners and managers.

Intimate Partner Violence as a risk factor for mental disorders: A Meta-Analysis. Jacqueline M. Golding

Law Commission Report No.231 (1995), para 2.46

Nice Guidance on "Domestic Violence and Abuse: How Health Services Social Care and the Organisations they work with can respond effectively". (February 2014)

Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey by M Hester, G Ferrari, S K Jones, E Williamson, L J Bacchus, T J Peters and G Feder in BMJ Open. 19th May 2015.

Safeguarding Vulnerable People in the NHS; Accountability and Assurance Framework (NHS England July 2015)

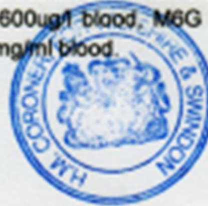
Serious Incident Framework (NHS England Patient Safety Domain March 2015)

The Revised Multi-Agency Guidance on the Conduct of Domestic Homicide Reviews. (Home Office 2013).

Appendix C: Coroner's Inquest Report

Shortly before 1400 on Wednesday 27 May 2015 more likely than not took a cocktail of drugs comprising Heroin in the main and also some Cocaine in the lavatory area of the eastbound side of . Drugs including heroin more likely than not were also taken as well earlier in the day. He returned to the car whereupon he began to physically deteriorate. Despite appropriate attention he soon became unresponsive and suffered a cardiac arrest from which, despite CPR, he did not recover and he was confirmed dead at 1527 the same day by an attending doctor.

at some point earlier that day had also taken methadone which would have exacerbated the toxic effects of the heroin in particular. died as a result of drug toxicity – Morphine 839ug/l blood, M3G 600ug/l blood, M6G 112ug/l blood - Methadone 0.1mg/l blood – and Cocaine 0.81 mg/ml blood.



APPENDIX D: - Bristol and South Gloucestershire statistics re Drug Related Deaths

Drug related deaths in Bristol

Background:
Drug related deaths in Bristol are reported through the Adverse Incident Reporting Procedure and reviewed by the Standards and Governance Committee Drug Related Death sub-group.
.
Since 2007/08 an average of 30 deaths per year has been reported. On average ~60% are identified as drug related with opiate overdose being the biggest causal factor (although rarely in isolation from other substances' involvement).

41 deaths were reported to the SMT In 2014/15 (see appendix one), and whilst 3 await toxicology/cause of death, the proportion that were drug related is expected to be broadly in line with previous years. All of those deaths attributed to overdose were opiate related

Outline
33 deaths of clients known to the Bristol treatment system and/or suspected of being drug related have been reported to the Substance Misuse Team since April 1st 2015 (nearly 80% of all deaths reported in 2014/15). 21 of the individuals were current ROADS clients at the time of death and 8 of the remaining 12 people had previous treatment episodes with providers in Bristol

Whilst the coroner has not issued causes of death for all of the cases, many of the deceased fit the profile characteristics for drug related deaths (male, over 40 years old, illicit opiate use, periods out of treatment, concomitant health needs etc).

To date, causes of death can be reasonably identified for 19 deaths:

-12 drug related (63%)
-3 suicide (16%)
-4 not drug related (21%)

2 further deaths are unascertained due to the length of time the bodies went undiscovered

The drug related deaths are broken down as follows:
9 opiate related overdoses:
-3x Acute morphine toxicity
-2x acute morphine and methadone toxicity
-1x Combined acute toxicity morphine and ethanol
-1x Mixed drug toxicity (methadone, cocaine, diazepam)
-1x Subaracnoid haemorage, Pneumonia. Morphine, methadone and cocaine toxicity
-1x Methadone, tramadol, diazepam, Amitriptyline and Desmethyldiazepam toxicity and Coronary artery atherosclrerosis

2 infections relating to injecting drug use:
-1x Infectious endocarditis
-1x 1a. Multiple organ failure. 1b. Sepsis. 1c. Infective endocarditis

1 alcohol related illness:

-1a. Myocardial infarction. 2. Alcohol liver disease

The 12 remaining deaths await the outcome from the Coroner's Office.
The Drug Related Death Sub Group has made recommendations that are currently being implemented to reduce further deaths:

-Primary care distribution of naloxone to all at risk clients (35 years old and over and reporting on top use)

-Health needs assessment of aging opiate cohort

-Clarifying GP registration process

Furthermore, the changes in legislation for the supply of naloxone will improve access to the drug and ongoing work is being conducted to reduce CA-MRSA bacteraemia amongst people who inject drugs.

	2014 /15	2013/ 14	2012 /13	2011 /12	2010 /11	2009 /10	2008 /09	2007 /08		Total
IC- OD	17	10	11	13	18	20	12	18		117
IC- Accidental poisoning	0	1	3	0	0	0	0	0		4
IC- Volatile Substances	0	0	0	0	0	1	0	0		1
IC- Other short-term causes	1	1	0	0	0	0	0	0		2
LTC- Long term complications	1	5	1	2	3	1	1	2		16
LTC- Heavy alcohol use	1	3	4	1	3	0	3	1		16
LTC- Smoking related diseases	0	0	0	1	0	0	0	0		1
Non-DRD	18	13	10	12	7	8	12	11		91
Awaiting Tox/CoD	3	0	0	0	0	0	0	0		5
Total	41	33	29	29	31	30	28	32		253
Drug Related	**20**	**20**	**19**	**17**	**24**	**22**	**16**	**21**		157
	48%	61%	66%	59%	77%	73%	57%	66%		

Non Drug Related/Open verdict/Awaiting Tox	**21**	**13**	**10**	**12**	**7**	**8**	**12**	**11**		96
	52%	39%	34%	41%	23%	27%	43%	34%		

Drug Related Deaths in South Gloucestershire

Background:
Any death of a service user in drug and alcohol treatment in South Gloucestershire whether drug related or not is reported to the Drug and Alcohol Action Team at South Gloucestershire Council for review.

Deaths in Service have risen in the period 2014/15, however direct drug related deaths remain low.

We were asked to put together a report on drug related deaths to inform the DRD and DHR panel due to a rise in deaths in Bristol to see whether this is reflected in South Gloucestershire and if there were any lessons to be learnt.

Outline
2014/15 – 15 deaths of clients known to the South Gloucestershire treatment system were reported to the Drug and Alcohol Action Team during 2014-15. Of these 10 were current clients of either DHI or SGSDAS at the time of death and the remaining 5 had all been known to treatment providers in previous episodes or in one case as a user of the needle exchange.

Of these 15 deaths:

Exsanguination, mixed drug intoxication (morphine and Methadone) – 1
Acute morphine toxicity - 1
Drug toxicity (amphetamine) 1
Methadone intoxication / infective exacerbation of chronic obstructive pulmonary disease – 1
Suspected heroin overdose – No COD confirmed – pending from coroner (1)

Gastrointestinal haemorrhage / Alcoholic liver disease – 1
Alcoholic ketoacidosis – 1
Not known not referred to coroner – 1 – alcohol client in poor health
Died in hospital – Liver cirrhosis, pneumonia,COD – Natural causes

Multiple injury (fall from height) – 1
Found unconscious at home - head injury - 1 (currently still part of murder investigation)

Pneumonia – 1
End stage COPD – 1
Heart disease – 1
Hypoxic brain injury / cardiac arrest – 1

Therefore 5 can be reasonably cited as Drug related death.

1 suspected murder
1 accident
6 other health complications
2 alcohol related complications.

2015 YTD

5 deaths reported. Of these all 5 were open to treatment services at the time of their death.

Terminal lung cancer - 1
Possible overdose based on what is known– no COD yet released - 1
COD unknown – not referred to coroner - 1
Alcohol related – COD unknown - 1
Died in hospice – health related (not drug related) - 1

All but the most recent death have been reviewed by the Drug Related Death / Death in Service panel which is comprised of a member of the South Gloucestershire DAAT, treatment services representatives and the GP drug and alcohol leads. There were no patterns which emerged and no significant lessons to report.

Appendix E. Lesbian Gay and Bisexual and Trans research Report for ROADS

The Diversity Trust (The Trust) is a social enterprise influencing social change to achieve a fairer and safer society. The Trust works across all sectors: corporate, public and social purpose. The Trust are equality, diversity and inclusion specialists, working across key equality legislation and policy areas. The Trust provides engagement, research and training.

INTRODUCTION
Gender reassignment and sexual orientation are often overlooked as a significant factor in health outcomes, and as a result there is a lack of data in this area. It is an area that is not routinely monitored in service provision and in most health and social care related research.

Current estimates the percentage of Lesbian, Gay and Bisexual (LGB) people ranging between 1.5% (Integrated Household Survey, 2011), and 5-7% (UK Government 2005) of the population.

The resident population of Bristol is 437,500. This would give an LGB population range between approximately 6,500 and 26,000 LGB people living in Bristol.

The Gender Identity Research and Education Society (GIRES), estimates the number of Trans people in the UK at 1% of the population being on a "gender variant spectrum". This would give a population of approximately 4375 Trans people living in Bristol.

The primary aim of this research report is to explore the need for targeted and specialist substance misuse treatment / interventions and support services for Lesbian, Gay, Bisexual and Trans (LGB and Trans) communities in Bristol.

RATIONALE

Gender reassignment and sexual orientation are 'Protected Characteristics' in the Equality Act 2010. Section 29 of the Equality Act 2010 prohibits discrimination in the provision of goods and services on the basis of gender reassignment or sexual orientation; it includes addressing the provision of services which are less accessible or of lesser quality than is provided to those who do not share a 'Protected Characteristic'.

In 2009, the Bristol City Council (BCC) Substance Misuse Team (SMT) commissioned the Trust to carry out a needs assessment with LGB and Trans communities in Bristol. This document is called 'Sorted Out' Click here for a summary.

There was a clearly identified need for more current research to take place and as a result in 2014 the Avon & Wiltshire Mental Health Partnership Trust (AWP), part of the Bristol Recovery Orientated Alcohol and Drugs Service (Bristol ROADS), funded this research.

1 Office for National Statistics (ONS) 2011.
2 'Gender Variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution'. Reed, B., Rhodes, S., Schofield, P. and Wylie, K. Gender Identity Research in Education Society. Surrey. (2009)

METHODOLOGY

This research was carried out between January and October 2014; and included: Surveys of providers; Follow up interviews with targeted and specialist service providers; Table-top/desktop literature review. The Trust was asked to find out, and report on, what targeted and specialist interventions were being delivered in other areas of the country including: identifying where there was innovation.

We promoted our research through various methods including: social networks, social media and other online media such as Facebook, LinkedIn and Twitter. We also used LGB and Trans specific social media. Organisations such as the National Consortium of LGBT Voluntary Organisations, the National LGB and Trans Partnership and the Lesbian and Gay Foundation (LGF) sent our survey out through their membership newsletters.

The Trust looked at:
Interventions targeted at same-sex relationships and substance misuse.

Steroid use amongst gay and bisexual men.
Gay and bisexual men injecting for 'chem sex', for example 'poly drug' use such as methamphetamine and-meth. Interventions targeting LGB and alcohol misuse. Interventions aimed at Trans communities and alcohol/substance misuse. Vulnerabilities of LGB and Trans children and young people and substance misuse.

From June and October 2014, the survey and interviews used a variety of methods to engage and question participant including; face-to-face, telephone calls and an online questionnaire. For a list of the questions please see the Appendix 2 (page 22).

Up to 40 people took part in the survey from a variety of agencies.
We followed this up with interviewing a number of individuals representing different service providers who were providing targeted and / or specialist support to LGB and Trans communities.

These agencies included:
ADS Manchester
Age UK
Bristol City Council
Lancashire LGBT
London Friend
Opening Doors London
Outreach Liverpool
Rainbow Head, London Borough of Barnet
Women's Link Hertfordshire and Wandering Women Hertfordshire

KEY FINDINGS
NATIONAL RESEARCH

The Lesbian, Gay, Bisexual & Trans Public Health Outcomes Framework Companion Document published by Department of Health in 2013 found a range of health inequalities experienced by LGB and Trans people. These inequalities included, but are not limited to higher levels of; anxiety and depression, self- harm, suicidal ideation, domestic violence and

abuse (DVA), and substance misuse. In short a ‘Toxic Trio’ of Suicidal Ideation, Mental Health and Substance Misuse.

Successive studies have shown that LGB and Trans people are more likely to misuse alcohol and drugs than the general population. However, due to a lack of consistent monitoring of gender identity and sexual orientation across drug and alcohol services, there is very little data on successful completion of alcohol and / or drug treatment by protected characteristics of gender identity and sexual orientation.

A summary of the key findings from the Public Health Outcomes Framework, 2013 include:

- Higher levels of health risk behaviours, such as alcohol misuse, substance misuse and smoking
- LGB and Trans people are less likely to engage with generic interventions and services.
- LGB and Trans communities have higher levels of need for interventions and targeted support.
- LGB and Trans communities are more likely to experience health inequalities in relation to public health areas and preventing premature mortality.
- LGB people demonstrate a higher likelihood of being substance dependent, dependence is highest amongst gay men and bisexual men and women.
- 24% of Trans people have used drugs within the last 12 months.
- 10% of trans people indicated signs of severe drug abuse using the Drug Abuse Screening Test.
- LGB and Trans people may have different patterns of substance use.
- LGB and Trans substance users may use a wider range of illicit drugs not recorded in the

British Crime Survey.

These findings are supported by additional surveys and reports. For more detailed information on the Public Health Outcomes Framework findings please see Appendix 1 (page 18-21).

Further evidence found from other sources includes:

The British Crime Survey 2013 shows that LGB people are three times more likely to have taken illicit drugs than heterosexual respondents. LGB people are more likely to take a Class A drug and five times more likely than the general population to use stimulant drugs such as page 8 cocaine, ecstasy, amphetamines and amyl nitrate. Lack of cultural competence of support agencies means LGB and Trans people believe generic services aren’t appropriate for them.

In the report by London Friend "Out of Your Mind" found that: *Higher levels of both drug and alcohol use have been reported within LGBT populations, although these groups report being less likely to engage in traditional substance misuse services, citing lack of understanding of the substance use and cultural needs amongst the barriers."*

Accessed online http://londonfriend.org.uk/wp-content/uploads/2014/06/Out-of-your-mind-executive-summary.pdf

TARGETED INTERVENTIONS

The Trust asked participants in the survey if they were delivering targeted interventions on substance misuse with LGB and Trans communities:

- 2 out of 16 respondents said they were delivering targeted interventions;
- 1 said they had a specific programme for LGB and Trans; 2 said they occasionally come across LGB and Trans people in their work who are using substances; 9 respondents said they are not delivering targeted services.

One of the respondents added that: *Interventions need to be evaluated properly, for example using cluster randomised trials, so that we know whether they work or not. We don't want unproven interventions wasting yet more time and worsening people's lives."* (Catherine Meads, Reader in Health Technology Assessment, Brunel University)

MEETING LGB AND TRANS NEEDS

The Trust asked participants in the survey 'to what extent they think services effectively meet the identity and / or holistic needs of LGB and Trans service users?'

- 3 out of 8 respondents said they thought that LGB and Trans needs were 'Very unmet';
- 2 thought that needs were 'Unmet';
- 2 thought that needs were 'Neither met no unmet';
- 1 preferred not to say.

Several respondents provided additional comments: *Trust, discrimination, most mainstream service staff are completely unaware of the LGBT community and LGBT specific needs, the fear of all of the above is also a huge barrier."* (Jen Fidai, Director, Rainbow Head).

The most common barriers are that LGB&T people expect discriminatory treatment, or feel that their needs will not be understood." (Anonymous)

With gay men there are a lot of body issues that aren't addressed and since the services are only catering for straights (heterosexuals), they miss the target. For lesbians, there are no specific alcohol abuse services and the straight services are making assumptions about lesbians that aren't true and it's putting lesbians off. In some places alcoholics anonymous is the only service offered and that's religious based and many lesbians are atheists so won't go. For trans people the main services are catering for transitioning but not looking at other

health needs and health behaviours. Other service users make life difficult for trans people and these aren't challenged by the service providers." (Catherine Meads, Reader in Health Technology Assessment, Brunel University)

Often LGBT do not come out when accessing generic/inclusive services. Having to come out might actually stop them - we have conducted some local surveys as have Liverpool Mental Health Consortium, which bare this out. Generic services often do not ask about sexuality and in terms of monitoring some services (e.g. CAB - OUTreach Liverpool is a project of North Liverpool CAB) are very bad at capturing info on sexuality and gender identity so are invisible in terms of services. Confident, out, professionals / middle class LGBT people tend to like generic services, but the most disadvantaged LGBT people seem to want and benefit from specific LGBT services or services
that are linked to or grounded in local LGBT communities. When in crisis, especially if isolated and lonely, LGBT people want LGBT-specific services and often to talk to someone of the same sexuality and/or gender identity."

(Joe Lavelle, Projects Coordinator, OUTreach Liverpool/North Liverpool CAB)

I think it varies enormously. As there's nothing specific it must be a bit of a lottery. Also even with 'out' LGBT workers like myself, there are generational issues to consider. I'm 57. When I was active on the commercial Gay Scene, drug-taking was more hidden and mostly what I witnessed was Poppers and Cannabis smoking. The whole Gym-related drug scene is a world I know little about." (Jane Mowat, Floating Support Worker, Sanctuary Supported Living)

Our experience is that many generic services are not LGBT competent, in both awareness of the drugs LGBT people are more likely to be using, the harms associated with these (e.g. dependency on GHB/GBL) or the contexts in which they use. LGBT people tell us they feel unable to be fully open about their lives and their behaviour in these services. Some have told us they have been restricted to services only in their local area, or have had to change services if they have been rehoused in a new area, and have experienced varying levels of LGBT competence. An additional barrier is services not fully championing LGBT equality or believing they can improve service provision by one- off training alone; improvement is better achieved if a provider engages with this in a more strategic way." (Monty Moncrief, Chief Executive, London Friend)

PREFER NOT TO SAY

The Trust asked participants "Do you think there is a need for targeted and / or specialist LGB and Trans services to be developed?":

Î12 out of 16 respondents said there is a need for targeted and / or specialist services.
Chart:1 Need for Targets or Specialist service

SPECIALIST SERVICES

- YES
- NO
- DON'T KNOW

In the report "Out of Your Mind" by London Friend found that: *A strong desire was expressed for access to specialist LGBT services, which were felt to offer an emotionally and physically safer environment, and which were felt to better understand the differing support needs related to service users sexual orientation or gender identity. Many who had used generic services felt they had been unable to fully disclose or explore their issues; sensitive topics such as sexualised using were felt difficult to disclose, particularly in group settings."*

Accessed online http://londonfriend.org.uk/wp-content/uploads/2014/06/Out-of-your-mind-executive-summary.pdf

The Chief Executive at London Friend in an interview said: *Our experience is that many generic services are not LGBT competent, in both awareness of the drugs LGBT people are more likely to be using, the harms associated with these (e.g. dependency on GHB/GBL) or the contexts in which they use. LGBT people tell us they feel unable to be fully open about their lives and their behaviour in these services. Some have told us they have been restricted to services only in their local area, or have had to change services if they have been rehoused in a new area, and have experienced varying levels of LGBT competence. An additional barrier is services not fully championing LGBT equality or believing they can improve service provision by one off training alone; improvement is better achieved if a provider engages with this in a more strategic way'* (Monty Moncrief, Chief Executive, London Friend).

He went on to say:

Our research indicates a strong preference by a majority of LGBT people to access specialist support. LGBT people have told us they feel safer in specialist settings, and that they have more confidence in the service if it is targeting them. In substance misuse this can be about understanding the drugs that are more prevalent within these populations, but also about understanding the contexts in which they use and the reasons for using. Some service users have said they would not attend mainstream services, sometimes based on the perception of prejudice or having experienced this from other services. Whilst some LGBT people prefer to access mainstream services there is still a need to improve LGBT awareness within these, and also essential that those who require specialist support have access to it. Specialism can

work in different ways from separate stand-alone LGBT provision to some time through the week allocated to LGBT sessions." (Monty Moncrief, Chief Executive, London Friend)

The Trust asked our participants which types of services this applies to with many highlighting a need for more than one services:

- 9 felt the need for specialist domestic abuse services;
- 10 felt the need for specialist sexual violence services;
- 10 felt the need for specialist services for sexual exploitation;
- 10 felt the need for specialist substance misuse services.

One of the respondents added that:

When LGBT people are facing crises they often want to have a connection to LGBT communities. Mainstreaming or inclusive services are great in principle, but some LGBT people are anxious when they have to talk in detail about their sexuality or come out to strangers who represent some form of authority. This is especially the case for people who express intersectionality in terms of their identity – e.g. gay and black, disabled and lesbian, trans with a mental health issue, etc. We work with many LGBT people who simply do not access non-LGBT services because of stigma about sexuality, drug/alcohol use, mental health, lifestyle, HIV status and other aspects of life/identity. ." Joe Lavelle, Projects Coordinator, OUTreach Liverpool / North Liverpool CAB

CASE STUDY:
ANTIDOTE
Antidote is a specialist LGB and Trans drug and alcohol treatment service. Antidote provides assessment, key working, relapse prevention, peer support, complementary therapies and counselling. Where clients require support other than psycho-social interventions (e.g. detox, prescribing) they work in partnership with the CNWL Club Drug Clinic or local services. Antidote also provide satellite outreach in sexual health settings and GUM clinics, targeting people using drugs for sex. "Chemsex" (the sexualised use of drugs by gay, bisexual and other men who have sex with men - MSM) Antidote were the first service in the UK to identify this trend and have been providing services to clients and training to professionals on this for a number of years. Work around chem sex now accounts for the majority of Antidote's work with a high prevalence of injecting. The three main presenting drugs are now methadone, crystal methamphetamine and GHB/GBL. Increasingly MSM users seeking support report injecting and use of these drugs in sexualised contexts with multiple partners. Concern has also been raised at the role use of these drugs may play in HIV transmission, with the number of new infections amongst MSM rising."
Lesbian and Bisexual Women
Antidote run a monthly clinic targeting lesbian, bisexual and trans women. It has been difficult to engage with this group though, the vast majority of Antidote services users are men.
Trans Women and Men
Specialist support is available through Antidote, and Antidote are a partner in cliniQ, a specialist trans health and wellbeing clinic offering sexual health, drugs, alcohol, counselling, advocacy, housing etc. from one central London location in a GUM service.
page 13.

CONCLUSIONS

Many LGB and / or Trans people report feeling 'invisible', therefore access to services is often framed by a general lack of awareness or understanding either about gender identity and / or sexual orientation.

Depending on issues such as attachment to LGB and Trans communities, being "out" in the environment, being resilient when accessing services will all depend on how LGB and / or Trans people feel when accessing support.

The most disadvantaged sections of the LGBT community will always need LGBT-specific services that link them to the LGBT community. The more affluent, self-assured, LGBT people may not require LGBT services at all." (Joe Lavelle, Projects Coordinator, OUTreach Liverpool / North Liverpool CAB)

RECOMMENDATIONS FOR PROVIDERS

From this research report we recommend that Bristol ROADS providers:

Give consideration for the development of an LGB and Trans specialist / targeted service in Bristol. This could include outreach, in-reach, group work and counselling as well as the development of targeted resources to promote the specialist service;

Ensure the development of specialist / targeted LGB and Trans services is supported by research, is evidence based and evaluated;

Providers should take a strategic approach; include the needs of Lesbian, Gay, Bisexual and Trans populations in service design and delivery; including development of an LGB and Trans substance misuse inclusion plan;

Use different approaches for different groups. For example, the needs of lesbian and bisexual women; the needs of gay and bisexual men and the needs of Trans women and Trans men can be different;

Drug and alcohol use amongst lesbian and bisexual women is higher than the general population of women. Specialist and / or targeted support and intervention is required with lesbian and bisexual women;

- Provide training on LGB and Trans and substance misuse for staff;
- Ensure consistent and effective monitoring of gender identity and sexual orientation across

Bristol ROADS;
Ensure policies and procedures are LGB and Trans friendly;
Ensure built environments are LGB and Trans friendly; carry out an audit built environments;
Ensure good customer feedback from LGB and Trans clients;
Ensure good engagement and outreach with LGB and Trans communities;
Identify LGB and Trans equality champions within agencies;
Develop a range of resources, targeting LGB and Trans communities (especially MSM), with harm reduction messages on alcohol and substance misuse.

RECOMMENDATIONS FOR COMMISSIONERS

The Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy should include the specific health needs of gay, bisexual and other men having sex with men (MSM); lesbian and bisexual women; Trans women and Trans men; including the specific substance misuse needs of these populations;

Collection of sensitive gender identity and sexual orientation monitoring data should be consistent;

Further research is required with Trans communities and substance misuse to better understand the prevalence amongst Trans communities;

Service specifications should address LGB and Trans specific needs and outcomes; Carry out an LGB and Trans audit of providers.

Appendix F New focus on improving access to domestic abuse services for LGB and Trans communities

Funding from Avon and Somerset Police and Crime Commissioner Sue Mountstevens' Community Safety Grant, issued to Safer Bristol Partnership has been awarded to Next Link, working with the Diversity Trust, to improve access to domestic abuse services in the region for Lesbian, Gay, Bisexual and Trans communities.
The project will focus on the barriers to domestic abuse services experienced by LGB and Trans communities across Bristol and Avon and Somerset (including Bath and North East Somerset, North Somerset, Somerset and South Gloucestershire). The two organisations will work together to improve access to services and the programme includes; a review of existing services, staff training, and research and the design of a campaign to increase reporting and referrals.
'The Avon and Somerset Police and Crime Commissioner, alongside the Safer Bristol Partnership is pleased to be funding this project aimed at improving the Lesbian, Gay, Bisexual and Trans communities' experience of accessing domestic violence and abuse services. No victim should feel that they can't access support, or that support services aren't able to meet their needs. We're certain that the progress that will be made as a result of this project will ensure key improvements in services, and encourage more victims from these communities to seek help.'
Avon and Somerset Police and Crime Commissioner Sue Mountstevens said: "I fully support the work of Next Link and the Diversity Trust in raising awareness of domestic abuse particularly amongst LGB and Trans communities. I would advise anyone that is affected by this crime not to endure this suffering alone and by coming forward you will also be helping others who have not yet found the confidence to report. If you are a victim of domestic abuse the police and agencies such as Next Link and the Diversity Trust are there to help you, so please come forward."
Pommy Harmar, Senior Manager of Next Link Domestic Abuse Services said, "There were over 7,000 recorded incidents of Domestic Abuse last year in Bristol and we know that this is just the tip of the iceberg and that two-thirds of incidents go unreported. It is deeply disturbing that the number who come forward from LGB and Trans communities is significantly lower and we want to do everything we can to improve access to ours and other services across the region. We are privileged to be working with the Diversity Trust and together with funding from the Police and Crime Commissioner we are confident that we will develop significant new approaches"
Berkeley Wilde, Director of the Diversity Trust said: "We are delighted
to be working with our partners at Next Link to improve access to domestic abuse services for LGB and Trans communities throughout the region."
"We know from our own research across the region, and from research published throughout the UK, LGB and Trans people are disproportionally affected by abuse and are less likely to report abuse. We want to help to improve access to services so that LGB and Trans people feel more confident to report abuse."
"If you would like to take part in the programme, or find out more, please do get in contact."

Appendix G RESEARCH AND ENGAGEMENT WITH YOUNG MEN EXCHANGING AND/OR SELLING SEX TO MEN (Produced by Diversity Trust but yet to be published)

1. INTRODUCTION

Little is known about the extent of the prevalence of young men exchanging or selling sex to men. Work was previously being carried out locally in Bristol by the Terrence Higgins Trust. This work came to an end, through lack of funding, approximately 10 years ago (2003-04).

In the Safer Bristol Partnership 'Violence and Abuse Strategy' (2012-2015) it states:

> *"Although the male street sex market is smaller than the female street sex market, there is a knowledge gap concerning the male and transgender street sex market and needs of Bristol's male and transgender sex workers."*

There is a clear need for a programme of research and engagement activities with: service providers, particularly specialist service providers working with young men; and with young men involved in exchanging and/or selling sex to men.

2. DEFINITION

Young men who exchange and/or sell sex to men are often marginalised; are hidden from society; are often socially excluded; and experience a range of health and other inequalities. The young men are from a range of different backgrounds including: homeless young men exchanging or selling sex for money, food, favours or a bed for the night; students looking to supplement their income; young gay men occasionally selling sex to earn extra income; young men who are formally involved in the 'sex industry' on a longer term basis for example as escorts or agency workers.

Lee and O'Brien (1995) defined young men exchanging and/or selling sex to men as:

> *"An activity where sexual acts are exchanged for payment, payment need not be for money but it could be a place to stay, something to eat, drugs or other payment in kind. Indeed a young man's introduction to prostitution may occur when he is without the basic necessities, and his continuing involvement happens when these basic needs are not met from elsewhere. It could, therefore, be argued that for many young men prostitution is a survival activity."*

3. RESEARCH CONTEXTS

Research conducted by Project Sigma in the early 1990s identified a site in one area as being *'commonly used by up to 40 male sex workers over a six month period'*, however when this was followed up a few years later there were few visible signs of this activity continuing. It was suggested that this was because of changes to the physical environment in the area. (Coxon, 1993).

Most research has not uncovered the existence of male massage parlours or agencies. Anecdotal evidence from the LGBT media suggests there is a large and thriving male masseur/male escort scene in the UK.

4. MONEY, GOODS AND GIFTS

Many young men involved in the sex industry do not see themselves as 'sex workers', but are opportunistic, when the situation or need arises they exchange or sell sex for money, goods, favours or a bed for the night. For many young men entering and continuing sex work it is a case of 'being in the right place at the right time' rather than a career choice.

On the surface the most immediate need of young men exchanging and/or selling sex is money or other goods. Many of the young men known to do street sex work are homeless, unemployed, or otherwise marginalised. Their sex work is on an 'as needs' basis, rather than a regular source of income. Sex work offers a quick way to gain access to extra money, food or other goods as and when needed.

For others, sex work may give an additional source of income, they may be on income support, in part-time work, students or just wanting extra money. Their sex work may not be regular - only occurring when they need extra money. It is likely that these young men have organised sex work into their lives and have clear boundaries about what is work and what is social.

5. SURVIVAL STRATEGIES

For many young men selling sex the 'work' is not the most important issue for them. It is unlikely they will see themselves as being 'sex workers', and they may act negatively to the term being used to describe them and any connection to being perceived to be 'Bi' or 'Gay'. Sex work may be just one of the strategies young men use to survive and to get what they want or need.

Existing research suggests for many young men, sex work is just one part of an overall life pattern. Young men don't plan a life of sex work, but many events, circumstances and situations bring them to where they are. For some young men sex work may be the first step or an additional sign of them expressing their bisexuality or homosexuality. For others it is just 'a means to an end'.

The challenge for services providers working with young men is to increase the range of choices available to meet their specific needs. If exchanging and/or selling sex for affection is the only way a young man can feel nurtured and protected then removing him from sex work will not alleviate this need - it will only deny the sole available source.

6. INVISIBILITY

Almost all service providers draw a blank when asked what current services are available for young men exchanging and/or selling sex. Many commissioners and providers who deal with homeless or 'at risk' young people, or who work with female sex workers have often not thought about the issue of young men exchanging and/or selling sex.

This invisibility of male sex work in services is likely a result of its hidden and underground nature. This is in contrast to female sex work which is often organised (e.g. massage parlours, agencies) and in public view (e.g. street sex work). In addition, the invisibility of LGBT issues means the fact that a young man may have sex with another man, for whatever reason,

is not often even considered. Even where it is considered, strong negative reactions from young men, and even from some professionals, means it may be difficult to develop work in this area.

7. SERVICE PROVIDERS

There are currently very few specialist, dedicated services across the UK which deal primarily with young men exchanging and/or selling sex. A number of services may deal with this issue as an aside to their core work. For example, sexual health services will come into contact with young men exchanging and/or selling sex, mostly those who do 'private' work and have integrated sex work into their lives.

Social Care is another key agency, and they are most likely to come in contact with the group, mainly through working with young men who are 'looked after' by the local authority. The ability to work with young men on a long-term basis is an advantage, however the ability of Social Care to provide this type of service is limited. The need for a referral service that would be seen as 'professional' by Social Care should be recommended.

Many professionals working with young men recognise most sex workers would not see Social Care as a supportive agency, but one they were either *forced* to go to or one they tried to stay away from. This means only those young men who are in the care of Social Care, or who have been referred, will be likely to get support from the agency. There is clearly a need for a specialist service where young men could go, of their own 'free will', where they would feel comfortable disclosing sex work and other risk behaviours. Providing a non-judgmental, sex positive, safe and friendly environment where they can access advice, support and information.

8. SEXUALITY: MALE SEX WORKERS AND THEIR CLIENTS

Many young men find it difficult to admit they are exchanging and/or selling sex to men and many more find it uncomfortable dealing with their own sexual and emotional feelings. When you couple both of these factors together young men involved in sex work can become fearful of the feelings they are experiencing.

In an unpublished study in 2001 it was noted many of the clients who use the services of young male sex workers, were married men, and kept their visits a secret from their wives. In fact it was identified that 75% of the clients were married men, generally confused about their own sexuality, and all they want to be able to do is "touch and feel another guy".

One male sex worker was quoted in the study as saying: "this generation is changing and it is becoming easier to be gay now, but in the last generation everyone got married. I have a lot of regulars whose sex life with their wives has failed to satisfy them and I know a lot of frustrated women out there!"

9. ACCESS TO SERVICES

A particular concern is the lack of access to health and medical care. Many young men involved in exchanging and/or selling sex access hospital Accident and Emergency in times of crisis, and don't access any other health or medical services, including sexual health services. The current system of registering with a General Practitioner, or even having to

make an appointment at a clinic or health centre does not fit with the chaotic lifestyles of many of the young men. Many of the services would be seen as intimidating, ‘too official’, by young men exchanging and/or selling sex. Even if they did access them they may not feel comfortable disclosing sex work or other types of risk behaviours, for example unprotected anal intercourse (UAI) etc.

Current services for young people have very little contact with young men who exchange or sell sex. This is in part due to the very hidden and marginalised nature of male sex work to men, but also a result of most services not seeing it within their mandate to work in this area. It is therefore difficult to assess the extent of male sex work to men.

Any future service development or provision to this group should be conducted as an integrated, evidence-based and holistic service, perhaps along the lines of a ‘one-stop-shop’ based within in a city centre. Research into current service provision is essential if we are to understand the level of social exclusion, inequalities and access to services experienced by this hidden and marginalised group.

10. LOCAL CONTEXTS

In June 2013 the University of Bristol and the Diversity Trust, hosted a ‘round table’ meeting to explore the local context for young men exchanging and/or selling sex in Bristol. Organisations invited to attend included: Avon and Somerset Constabulary, Barnardo’s BASE, Brook, One25, Safer Bristol Partnership and Terrence Higgins Trust.

10.1 Barnardo’s BASE

Barnardo’s BASE in Bristol works with young people, including boys and young men, who are at risk of sexual exploitation or who are being sexually exploited. They offer practical help to young people to help them deal with immediate difficulties they face.

Approximately 15% of the young people BASE see’s are young men between the ages 10-18. The referrals are mostly from Social Care, Health, GP’s, sexual health, schools and the Police. The average age of young men first contacting BASE is age 14 years.

This support is offered to young people up to the age of 18 years.

10.2 One25

One25 work with women over the age of 18 and provide case-work, drop-in and outreach services 5 nights a week in Bristol. One25 have noticed a change with the development in online technology with women increasingly advertising online. Women working on the streets have decreased from an average number of 30 per night to 6 per night. Many women accessing the service are on scripts and require support around housing. Women working from a house/online tend to be less chaotic and are less likely to be working on the streets. Although there has been a decrease in the numbers of women working on the streets, the project is working with the same number of women. One25 does work with Trans women (MtF) when they present to the service.

10.3 Terrence Higgins Trust

Terrence Higgins Trust (THT) in Bristol provided a street outreach service to young men exchanging and/or selling sex until the mid 2000's. The project was part of a Bristol wide project known as Pandora, and included partner organisations including Barnardo's BASE. The project was funded by the Home Office. The project funding ended in 2003/04 and the outreach service has not been provided for approximately ten years.

Owing to dwindling numbers, the development of the internet/smart phones, and the funding being ceased the work was discontinued. THT have received no recent referrals from the police but they do get calls from local police departments with usually unfounded concerns relating to relationships between older and younger men.

QUESTIONS FOR FURTHER CONSIDERATION

1. How many service providers are currently in contact with young men exchanging and/or selling sex?
2. Are there no services being delivered, targeted at young men exchanging or selling sex, because there aren't that many young men involved in sex work?
3. Or, are young men not accessing services because there aren't any specialist services being delivered?
4. Are young men involved in sex work more vulnerable than students supplementing their income?
5. Is there an increase in the power imbalance between a client and a young man exchanging and/or selling sex?
6. Where do young men go after they have left Barnardo's BASE, when they reach the age of 18, for advice, support and information.
7. How do we explore the complex interplay between identity, sexuality and exchanging and/or selling sex (and sexual exploitation)?
8. Is there such a homogenous group as "young male sex workers"?
9. What are the health, care and support needs of young men exchanging and/or selling sex?

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Appendix H

Lighthouse
Integrated Victim Care Programme

In 2011, the Avon & Somerset Criminal Justice Board initiated a project to better understand the end to end journey of a victim of crime. It found that there was significant overlap and duplication in some areas, and gaps in others. A key recommendation was to simplify the landscape for victims, seeking to re-align key victim services into one, more holistic, multi-agency model - drawing on learning from other successful integrated models such as IOM.

This project was an important pre-cursor to what is now known as the Integrated Victim Care programme, fostering a shared ambition amongst the criminal justice and community safety partners to develop a more coherent and 'joined-up' response to victim needs locally.

The programme led to the creation of the Lighthouse Victim and Witness Care teams. This new approach went live on October 1st 2014.

Drivers for change

There were a number of key drivers which led us to evaluate, analyse and redesign our approach to victim care, including:

✓ **The new Victim's Code of Practice**, which came into effect in December 2013. It details a minimum level of service to which all victims are eligible, and places an emphasis on the police conducting thorough needs assessments for victims and signposting to support - with services focused on victims of greatest need according to four clearly defined 'priority groups'.

✓ **The EU Directive on the rights, support and protection of victims of crime**, which has been formally adopted by the UK and must be implemented by all member states by 16th November 2015. Responsibility for providing services within the directive rests largely with PCCs, including providing all victims with access to free and confidential support services (regardless of whether or not a crime is reported) and advice on practical matters. It also requires that victims with specific identified needs will be provided with more specialist support, such as counselling.

✓ **The devolvement of victim services commissioning responsibility to PCCs**. Following the 'Getting it Right for Victims & Witnesses' consultation early 2012, radical recommendations were adopted to devolve MoJ victims funding to PCCs for local commissioning from April 2015 (plus additional funding being raised from reform of the victim surcharge arrangements and other sources). Avon and Somerset are one of just 7 'early adopter' areas who will be moving away from the existing national commissioning arrangements from October 2014.

Background to the Programme

The programme was initiated in May 2013 by Avon and Somerset Constabulary and the Police & Crime Commissioner's Office. It is led by a multi-agency programme board (established in October 2013) with wide representation from criminal justice and community safety partners.

The Board developed a shared vision and strategy for victim care, which was published in November 2013.

Objectives

A crucial objective of the programme was the implementation of new 'Integrated Victim Care' teams across Avon and Somerset, by October 2014. The teams bring together victim contact functions in the Police service, co-located with partners, to provide more coordinated, end-to-end care for victims. These teams sit alongside a parallel commissioned service to meet the more specialist victim needs, including support for victims who do not wish to report to the police. These Integrated Victim Care Teams are now called Lighthouse.

Other key objectives of the IVC programme were:

✓ Commissioning services to ensure that victims have access to appropriate support (including victims who choose not to report to the police) and align partner strategies and commissioning processes to improve accessibility, consistency and standards of support for victims in Avon and Somerset.

✓ Developing robust, common needs assessments, processes and referral mechanisms to ensure that victims have access to appropriate support.

✓ Refining monitoring and service improvement arrangements to enable more active listening to the voice of victims – including consultation and complaints mechanisms.

✓ Developing a more victim-focused approach to the delivery of restorative justice, embedding this practice across the criminal justice process and increasing opportunities for victims to take part in RJ.

What do the new Lighthouse Victim and Witness Care teams look like?

The teams consist of police staff and key partner organisations, co-located into multi-agency 'hubs'. The hubs pick up all serious crime cases (including hate crime, sexual and domestic abuse) and those that involve victims who are vulnerable, intimidated or persistently targeted (as defined in the Victim's Code of Practice). They are co-located with the Police safeguarding units, and aligned closely with the other 'managing people and places' functions of the new constabulary operating model.

Lighthouse is a team of 82 Police Staff members, working out of 3 hubs, covering the entire Avon and Somerset Constabulary Force area. They work extended hours, covering weekends and evenings, in order to be available when victims need them most.

The new teams:

✓ guide a victim through their journey from first point of contact with the police, through the investigation and on to the end of the criminal justice process

✓ provide greater ownership of the whole journey of a victim, reducing handovers and providing a 'single point of contact' approach—simplifying the landscape for victims

✓ ensure victims receive adequate and tailored support – through co-located, integrated partnerships to ensure smooth handovers, effective information transfer and 'one-team'

Appendix I Chronology

Key: Agencies:

Colour	Agency	Pseudonyms
	Bristol Drugs Project	Michael': Pseudonym for Victim
	DHI	Dan' : Pseudonym for Victim's Partner
	Avon and Wiltshire Mental Health Partnership (AWP) Criminal Justice Intervention Team (CJIT)	BB: Ex Partner of Michael
	Boots Pharmacy	
	South Western Ambulance Service	
	Salvation Army	
	Solon Housing	
	Avon and Somerset Police	
	SGC: Adult Safeguarding	
	Bristol City Council Housing Advice Team	
	St Mungos Broadway	
	Sirona Care and Health	
	North Bristol NHS Trust	
	South Gloucestershire Clinical Commissioning Group	

Agency	Date	Time	Source of Information	Agency Name & Sector/Dept if relevant	Significant & Relevant Events: details of contact, including whether the victim was seen/ wishes and feelings sought and recorded	Action Taken	Author Comment
Bristol City Council Housing Advice Team	October 2012				Michael was referred to the Housing Advice Team in October 2012 and was placed in a number of supported hostels culminating in a placement in Bristol which is low-support accommodation managed by Places for People.		

St Mungos Broadway	24/10/2012	14:45	OPAL database	St Mungos Broadway Outreach	Michael presented (self-referred) to the Duty Outreach Worker at the Compass Centre as homeless. Provided with information on emergency accommodation and an appointment for a full assessment the following day at 10am. Stated that he stopped drinking the night before and was experiencing some withdrawal symptoms.	Appointment given for full assessment to identify housing options. Referred to Clinic that day to meet Dr for support around alcohol use and potential withdrawal symptoms.	
St Mungos Broadway	25/10/2012	10:16	OPAL database	St Mungos Broadway Outreach	Michael did not attend assessment arranged for 10am.	Target client on street outreach sessions.	

St Mungos Broadway	26/10/2012	13:55	OPAL database Paper assessment form	St Mungos Broadway Outreach	Presented for assessment for support around accommodation; completed by Outreach Worker. Stated he had been rough sleeping 3 nights in Bristol. Before this he was in ███ ███ and left there after a relationship breakdown. Stated he was 3 days clean from heroin, diazepam and alcohol and was suffering from withdrawal symptoms. Help was given to Michael to set up a benefit claim (ESA). Assessment was challenging as Michael did not really want to discuss his mental health needs apart from being admitted to hospital on a couple of occasions in █████. He reported no history of self-harm, however ███ ███ noticed cuts on his arms that were not recent and were not heavily scarred. Michael stated he felt low due to current situation. Discussed where he could access support and he was advised to attend Compass Centre daily. He chose to come to Bristol as it was the only area known to him and his ex-partner lived in the area. Michael disclosed support needs around depression, anxiety and suicidal ideations and stated he had been using drugs (including heroin and benzodiazapines) and alcohol since the age of 17. Discussed drinking vodka until he passed out. He had been clean for 6 months when he was aged 19 by attending meetings.	Advised to present to the Emergency Duty Team at a Police Station for emergency accommodation over the weekend and present back at the Compass Centre on Monday 29th October. Monitor mood, mental health presentation and cycle of drug/alcohol misuse. █████ referred client to 'Share' dry house and a room was reserved for him for the following Monday.	Michael did not have a Local Connection to Bristol. Recorded connection was ██████ Borough Council. Michael stated he had been in Bristol since February 2012 and did not want to return to █████.

St Mungos Broadway	29/10/2012	10:51	OPAL database	St Mungos Broadway Outreach	Michael presented and said he managed to stay at a friend's place the previous night. Michael reported using morphine. Michael had an appointment with Compass Health regarding scripting. Referred him to Addiction Recovery Agency (ARA), for accommodation. ARA made contact and they were willing to offer an assessment. Michael advised to attend ARA drop in on Friday.	Information regarding Bristol Drugs Project provided.	
St Mungos Broadway	01/11/2012	12:00	OPAL database / Housing Support Register	St Mungos Broadway Outreach	Michael was assessed and accepted for an Extra Support Bed room and moved in that day.	Information provided to property about Michael's benefit claim.	
Salvation Army	01/11/2012				Michael moved into property on 1st November 2012. He then requested a referral to the Bridge Rehab (now closed) and was transferred there on 20th November 2012. Michael is reported to have had a history of heroin use since age 17 and also high levels of Benzodiazepan use and Alcohol. While on the Bridge Program he was referred to substitute prescribing and appeared motivated to achieve abstinence though did struggle with this. Michael received several warnings while on the Bridge for non-engagement with the program and these, and the non-payment of his Service Charge, resulted in his eviction on 19th February 2013.		House is a Salvation Army Hostel, Level 1 however when Michael stayed here we still had the Bridge rehab and prep so he was mostly on that unit (program decommissioned in 2013). There is nothing on his notes or contacts to suggest any lessons learnt or recommendations for future practice.
St Mungos Broadway	14/11/2012	10:32:00	OPAL database	St Mungos Broadway Outreach	Phone contact between outreach worker and House to discuss Michael being assessed and refused by the Bridge Programme (a move on from the hostel) as his drug and alcohol use were too high.	Appointment offered to Michael to meet with outreach worker on 19th November to discuss his move on options from House.	

St Mungos Broadway	14/11/2012	11:18:00	OPAL database	St Mungos Broadway Outreach	Follow up phone call with [redacted] to cancel the appointment with outreach worker as Michael would be moving into the Preparation unit on 20/11/2012. Michael would be prescribed 40mgs Methadone mixture (no Diazepam) and would not require an alcohol detox.	Monitor move on from [redacted].	
St Mungos Broadway	20/11/2012	08:38:00	OPAL database	St Mungos Broadway Outreach	Michael's case is closed as he has been positively resettled.	Target if return to the streets.	
Bristol Drugs Project	07/01/2013		Theseus needle exchange database	BDP- High Support Team	Needle exchange. Check whether more than one vaccination for Hepatitis B. "*He usually gets others to inject him but is trying himself, please encourage this*"		
Bristol Drugs Project	19/01/2013		Theseus needle exchange database	BDP- High Support Team	Needle exchange recorded		
Salvation Army	27/02/2013		HSR Records		HSR records show that Michael moved into a hostel on 27th Feb 2013 and stayed there until 8th April 2013.		
Bristol Drugs Project	01/03/2013		Theseus needle exchange database	BDP- High Support Team	Needle exchange recorded		
Bristol Drugs Project	05/03/2013		Theseus needle exchange database	BDP- High Support Team	*"Confirmed only one HBV vaccination and advised to see nurse to update; he said he would go to compass centre…he lives in a hostel. Given extra pins as he's having problems with injecting"*		
S.Glos Clinical Commissioning Group	05/03/2013		GP Record	GP Practice 1	Letter received from Places for People Support Worker advising GP Practice 1 that Michael would be moving from a hostel into a flat and that he was on prescribed subutex (buprenorphine, an opiate drug) as part of a drug programme.	Filed	

S.Glos Clinical Commissioning Group	05/03/2013		GP Record	GP Practice 1	Michael registered with GP Practice and reported that this was his first registration with a GP in UK as he had been previously registered in █████. A new patient health questionnaire completed by Michael showed that his alcohol intake equated to hazard	Registered on practice system	AUDIT (Alcohol Users Disorders Identification Test) Screening tool score was 14. 0 - 7 = sensible drinking; 8 - 15 = hazardous drinking; 16 - 19 = harmful drinking and 20+ = possible dependence.
S.Glos Clinical Commissioning Group	08/03/2013		GP Record	GP Practice 1	Michael seen by GP1 in surgery, attended with support worker. Asking for subutex prescription, Full history taken - elicited history of crack cocaine and heroin use with some ongoing intermittent use in addition to subutex programme. Also reported a history		Instalment prescriptions for methadone and other controlled drugs are written/printed on FP10MDA forms which are blue to differentiate from standard prescriptions which are on a green FP10 form. FP10MDA will be called "blue script" in this chronology. Blue
S.Glos Clinical Commissioning Group	08/03/2103		GP Record	GP Practice 1	GP1 and GP2 discussed Michael. GP2 agreed to ongoing prescriptions and contacted dispensing pharmacy to confirm dose already being prescribed. GP2 noted that Michael had missed some days of previous prescription.		

Bristol Drugs Project	13/03/2013		Theseus needle exchange data-base	BDP- High Support Team	Needle exchange recorded		
Bristol Drugs Project	18/03/2013		Theseus needle exchange data-base	BDP- High Support Team	*"Client has missed hit resulting in an abscess on right arm. Checked out by Compass Health, given antibiotics. Client to access info sessions this week. Please check welfare next time in. Had 2nd Hep B Vacc. Two weeks ago"*		
Bristol Drugs Project	21/03/2013/ 03/06/2013		Theseus needle exchange data-base	BDP- High Support Team	7 visits to needle exchange recorded		
S.Glos Clini-cal Commis-sioning Group	26/03/2013		GP Record	GP Practice 1	GP1 reports telephone conversation with pharmacist - late presentation of 2 week prescription. GP1 advised that Michael would need to be seen in surgery before is-sue of next prescription.		Late request for blue script
Bristol Drugs Project	31/03/2013		Theseus needle exchange data-base	BDP- High Support Team	Needle exchange recorded		

Solon Housing	01/04/2013				Tenancy commenced with us on 01/04/2013. Michael was on the old RSI (Rough Sleepers Initiative) tenancy which is an assured short hold agreement. This particular agreement was for a maximum of 2 years and for those who needed direct tenancy support every week. The file notes show that for periods of time Michael did not engage with support. We also had complaints from his neighbour around his drug use and the smell of this, him ringing the neighbours buzzer as he forgot his keys several times and also that he had had a fire at the property where the fire brigade were called. He has also left £1950 of rent arrears on the account.		
Boots Pharmacy	05/04/2013	Daily	Store Manager & Pharmacist, with reference to Pharmacy Patient Medication Records(PMR)	Boots Pharmacy ███ ███████ Bristol	First Contact - Contract signed for Supervised Administration. First MDA Prescription Dispensed for: SUBUTEX 8mg tabs (x 1 daily) SUBUTEX 2mg tabs (x2 daily) ZOPICLONE 7.5 mg(x2 nightly)		
S.Glos Clinical Commissioning Group	05/04/2013		GP Record	GP Practice 1	Michael seen by GP3 in surgery for repeat subutex prescription, reported as having run out of medication and taking tablets given to him by friends. Also reports that Michael requested Zopiclone tablets (a hypnotic). Prescription issued.		
Salvation Army	08/04/2013				HSR records show that he moved into hostel on 27th Feb 2013 and stayed there until 8th April 2013.		

S.Glos Clinical Commissioning Group	11/04/2013		GP Record	GP Practice 1	Report received following attendance at Compass Health Walk in Centre. Michael reported as requesting sick note and zopiclone prescription. Med3 (sick note - not fit for work) issued for 26/3 to 25/4, reason "Opiate dependence". Advised that future prescr		
S.Glos Clinical Commissioning Group	16/04/2013		GP Record	GP Practice 1	Michael seen by GP1 in surgery who records a medical matter relating to prolonged masturbation by partner. Record of request for repeat prescription of medication, 2 weeks of zopiclone issued. GP1 advised Michael that he must return on 19/04/13 for blue script.		
Boots Pharmacy	16/04/2013		Store Manager & Pharmacist, with reference to Pharmacy Patient Medication Records(PMR)	Boots Pharmacy ███ ███████ Bristol	FP10 Prescription–ZOPICLONE 7.5mg tabs (x14) dispensed.	Then no further contact until 7/1/14	
S.Glos Clinical Commissioning Group	18/04/2013		GP Record	GP Practice 1	Copy of letter from BDP Practitioner 1 offering Michael an appointment for opiate substitute support.		
S.Glos Clinical Commissioning Group	19/04/2013		GP Record	GP Practice 1	Michael seen by GP3 in surgery. GP3 reports attendance for blue script. Also reports that Michael "mentioned injecting amphetamines into left forearm". Treated for infection in forearm.		

S.Glos Clinical Commissioning Group	25/04/2013		GP Record	GP Practice 1	BDP Practitioner 1 reports Michael attended BDP assessment I surgery. Added to shared care waiting list and offered regular appointments as soon as possible.		
S.Glos Clinical Commissioning Group	03/05/2013		GP Record	GP Practice 1	Michael seen by GP3 in surgery. Blue script issued. Med 3 issued from 03/5 to 03/7, reason "Drug dependence"		
S.Glos Clinical Commissioning Group	17/05/2013		GP Record	GP Practice 1	Michael seen in surgery by GP1 and given blue script and prescription for 2 weeks of zopiclone.		
Avon and Somerset Police	27/05/2013		PNC:13/233778D CRO: 72429/13L	Avon & Somerset Constabulary	Shoplifting (newspapers & cosmetics) from Asda Stores, Bristol.	Cautioned.	
S.Glos Clinical Commissioning Group	03/06/2013		GP Record	GP Practice 1	Michael seen by GP2 in urgent surgery. GP2 reports Michael requesting blue script - ran out previous week. Also reported as having lost weight recently due to not eating properly. Weight 65kg. Advice re high calorie diet, given sip feeds and further zopic		Late request for blue script
Bristol Drugs Project	06/06/2013		Theseus needle exchange database	BDP- High Support Team	*"some change talk, thinking about pod"*		
Bristol Drugs Project	13/06/2013 - 11/12/2013		Theseus needle exchange database	BDP- High Support Team	13 visits to needle exchange recorded		

S.Glos Clinical Commissioning Group	17/06/2013		GP Record	GP Practice 1	Michael seen by GP4. Blue script issued. Offered chlamydia screening - declined		Michael in age group for asymptomatic national chlamydia screening programme.
S.Glos Clinical Commissioning Group	03/07/2013		GP Record	GP Practice 1	Michael seen by GP1 in urgent surgery. Reported as saying he used heroin 2 days before and taking 30mg diazepam per day. Still waiting for BDP shared care appointment. Weight loss recorded - now 61kg, BMI 19.3. Urine screen requested. Michael advised that he must see same Dr fortnightly in normal surgery hours. Subutex dose increased to 14mg.		
S.Glos Clinical Commissioning Group	05/07/2013		GP Record	GP Practice 1	Phone contact from local pharmacy to GP1 reporting that Michael has failed to pick up daily prescription on occasions.		
S.Glos Clinical Commissioning Group	11/07/2013		GP Record	GP Practice 1	Michael seen by GP5 reported ongoing use of party drugs at weekends, trying to stop. Weight stable, advice re diet. Med 3 issued from 26/6 to 26/8, reason "Drug dependency". Michael asked by GP5 to see usual Dr for drug review.		
S.Glos Clinical Commissioning Group	17/07/2013		GP Record	GP Practice 1	Michael seen by GP1. Reported as saying had not used other drugs for 2 weeks. Blue script recorded as issued.		

S.Glos Clinical Commissioning Group	31/07/2013		GP Record	GP Practice 1	Michael seen by GP1 in urgent surgery. Michael recorded as reporting no use of street drugs. Recorded as requesting blood borne virus screen due to sharing needle 4 months earlier. Safe sex recorded. Blood borne virus and urine screen requested. Blue script recorded as issued.		GP1 had requested that Michael attend in normal surgery session rather than morning open access/duty doctor session. Drug urine screen showed opiates.
S.Glos Clinical Commissioning Group	02/08/2013		GP Record	GP Practice 1	Michael recorded as not attending for blood test		
S.Glos Clinical Commissioning Group	13/08/2013		GP Record	GP Practice 1	Michael seen by GP6. Post-dated blue script recorded as issued for following day. Michael recorded as smelling of alcohol but recorded as denying drinking or drugs. Some weight increase noted.		
S.Glos Clinical Commissioning Group	27/08/2013		GP Record	GP Practice 1	Michael seen by GP7 with tender swelling over forearm vein. Recorded as admitting to occasionally injecting drugs and thinking he had an abscess. Treated for infection and further investigations considered. Drug dependence discussed. GP7 asked Michael to book appointment with GP1 for the following day for review and issue of prescription. Rebooked blood borne virus and other blood tests.		

S.Glos Clinical Commissioning Group	28/08/2013		GP Record	GP Practice 1	Michael seen by GP1. Blue script issued. GP1 records asking Michael to see him in 2 and 4 weeks. Practice note sent to BDP practitioner 1 by GP1 to query length of wait to be seen.		
S.Glos Clinical Commissioning Group	28/08/2103		GP Record	GP Practice 1	Michael attended for blood tests		Results - all normal.
S.Glos Clinical Commissioning Group	10/09/2013		GP Record	GP Practice 1	Michael seen by GP8 who records issue of zopiclone prescription.		
S.Glos Clinical Commissioning Group	23/09/2013		GP Record	GP Practice 1	Michael did not attend booked appointment.		
S.Glos Clinical Commissioning Group	24/09/2013		GP Record	GP Practice 1	Michael seen by GP6 who records him as struggling, missed Friday pick up and late on Saturday, not allowed further medication by pharmacy as had missed 3 days. Recorded as "has a girlfriend - going well and may be some work". Blue script issued. Med 3 issued 28/8 to 28/11 "Drug dependency"		Record of girlfriend may have been report of having a partner. Good practice by pharmacy in close monitoring of drug usage.
S.Glos Clinical Commissioning Group	09/10/2013		GP Record	GP Practice 1	Michael seen by GP9. Blue script recorded as issued.		

S.Glos Clinical Commissioning Group	23/10/2013		GP Record	GP Practice 1	Michael seen by GP9. Detailed review undertaken. Abscess at injection site on right forearm. Recorded that Michael reported injecting "grams and grams of M-Cat (methodrone) intravenously using hundreds of pounds worth each week. When he tries to stop he feels extreme anxiety and shaking and feels suicidal. No plans of suicide but feels terrible. Aware he need to stop methodrone. Supportive discussion of long history of drug and associated psychiatric problems recorded. GP9 agreed to issuing one prescription for diazepam for short term relief of anxiety and to get Michael off methodrone. One prescription only and if not successful for no more until seen by BDP. Med 3 issued 29/8 to 24/10 and 23/10 to 23/12		First report of suicidal feelings on stopping methodrone.
S.Glos Clinical Commissioning Group	01/11/2013		GP Record	GP Practice 1	Michael seen by GP9 and recorded as saying he had missed daily pickups at pharmacy and needed new blue script. GP9 phoned pharmacy who reported not seeing Michael since 23/10/13 but would continue to issue daily medication. Michael recorded as overusing zopiclone and as saying he had stopped methodrone - encouraged by GP9. GP9 records telling Michael he would only issue weekly prescriptions for zopiclone and that Michael understood this.		

Avon and Somerset Police	07/11/2013		Assist: AS-20131107-0108	Avon & Somerset Constabulary	Michael has contacted the police to report a verbal domestic incident whereby his ex-partner is making threats towards him. Michael is refusing to disclose the offender.	Operator advised officers would need to speak to Michael but he refused to engage. Michael informed operator that the suspect has now left the property.	
S.Glos Clinical Commissioning Group	08/11/2013		GP Record	GP Practice 1	Michael seen by GP9 who records Michael reporting using 2-4 bags of heroin a day IV (10g), clean needles, needing something every 8-10 hours and using zopiclone 15mg (double dose) at night to sleep. GP9 planned to refer to BDP because the practice could no longer prescribe subutex as Michael using IV heroin again, to ask BDP to restart on substitute if appropriate. Record of message left for BDP practitioner 1 by GP9 about Michael to update about attendance at pharmacy and date of prescription.		
S.Glos Clinical Commissioning Group	12/11/2013		GP Record	GP Practice 1	Referral from GP9 to BDP for Michael faxed		
S.Glos Clinical Commissioning Group	22/11/2013		GP Record	GP Practice 1	BDP Practitioner 1 records Michael did not attend appointment. Letter had been sent, text message and telephone calls had been made = answerphone. BDP referral closed and request for new urine drug screen with new referral requested.		

S.Glos Clinical Commissioning Group	04/12/2013		GP Record	GP Practice 1	Michael seen by GP9 who recorded that Michael missed BDP appointment, records Michael as using 2-4 bags of heroin daily and drinking unknown quantity of vodka, wanting to be clean. GP9 agreed to new referral to BDP and requested up to date phone number. Zopiclone prescription issued.		
S.Glos Clinical Commissioning Group	05/12/2013		GP Record	GP Practice 1	Michael seen by GP9 re abscess at injection site. Infection treated and urine screen requested. Referral from GP9 faxed to BDP		Urine positive for opiates
Bristol Drugs Project	05/12/2013		Theseus database / client file		Referral received from GP		

AWP Bristol CJIT	10/12/2013	11:28:00	Theseus	CJIT	CJIT Required Assessment appointment: Michael assessed by Criminal Justice Intervention Team (CJIT) Worker A following positive test for Class A drugs in custody following arrest for an acquisitive crime. Michael reported that he uses heroin and crack daily. He states he is using around 6 bags heroin and 2 rocks of crack daily, injecting into his arms. Started heroin use at age 17. Stated that he is not currently scripted and is waiting for a prescription through his GP. No current cannabis use and alcohol use at weekends (4/5 cans beer). Client admitted to using alone sometimes in public toilets. Michael was in low mood and quite tearful, stated only second time he had been arrested, that he was accused of burgling partner's business. He claims that his drug use is funded by partner so he does not have to offend. Living in RSI housing; tenancy due to end 12th January.	Initial Care plan and risk screen completed by CJIT. New appointment set up for 16th December with Worker B, at [redacted] [redacted] as requested by Michael. CJIT for 1:1 key working, motivational interventions such as mind mapping around drug use; relapse prevention, confidence building, and support with accessing mutual aid groups. Worker A has discussed harm minimisation with Michael, including BBV risk, overdose risk etc.	Comprehensive care plan set up. CJIT do not write to GP's following RA's unless there are specific physical or mental health concerns.
Avon and Somerset Police	10/12/2013		PNC:13/233778 D CRO: 72429/13L	Avon & Somerset Constabulary	Burglary & Theft - Non-Dwelling	NFA - Insufficient evidence to proceed at this time.	
Bristol Drugs Project	11/12/2013		Theseus database / client file	ROADS Assessment Team	Assessment completed, including risk assessment & TOPS form	Opiate Substitution Treatment (OST) begun	
S.Glos Clinical Commissioning Group	11/12/2013		GP Record	GP Practice 1	Report of BDP assessment of Michael received by practice. Started on methadone. Safeguarding check done - no children in household.		

S.Glos Clinical Commissioning Group	12/12/2013		GP Record	GP Practice 1	BDP practitioner 1 records referring Michael to BSDAS in light of complicated drug use and poor mental health.		
Bristol Drugs Project	13/12/2013		Theseus database / client file	ROADS Assessment Team	Internal ROADS referral to BSDAS made		
AWP Bristol CJIT	16/12/2013		Theseus	CJIT	Appointment re-arranged by CJIT worker to 20.12.13		
S.Glos Clinical Commissioning Group	17/12/2013		GP Record	GP Practice 1	Message left for Michael on answerphone by GP10		
S.Glos Clinical Commissioning Group	18/12/2013		GP Record	GP Practice 1	GP11 records telephone conversation with Pharmacy 2. Michael reported as missing one or two pickups at weekend and was given 40ml instead of 60ml.		Pharmacy said they would report error and GP practice would review Michael.
S.Glos Clinical Commissioning Group	19/12/2013		GP Record	GP Practice 1	Michael seen by GP9 who records that Michael had been seen by BDAS and started on methadone 60mls daily pick up. Blue script recorded as issued.		
AWP Bristol CJIT	20/12/2013		Theseus	CJIT	CJIT f-up appointment: Michael attended appointment with CJIT Worker A. Discussed housing, and began motivational work.		
AWP Bristol CJIT	24/12/2013		Theseus	BDP/BSDAS	Referral to BSDAS core services Referred by BDP Shared Care to BSDAS core services for specialist prescribing and for Preparation for @Recovery Group following assessment on 13.12.2015 and identification that client is Gay Sex Worker and vulnerable.		
AWP Bristol CJIT	30/12/2013		Theseus	BSDAS	Letter sent to Michael with an appointment for 6.01.2014, following unsuccessful attempts to contact Michael by telephone.		

S.Glos Clinical Commissioning Group	03/01/2014		GP Record	GP Practice 1	Michael seen by GP9 who reports Michael doing well. Blue script recorded as issued.		
AWP Bristol CJIT	06/01/2014		Theseus	BSDAS	BSDAS assessment appointment: Michael did not attend.		
AWP Bristol CJIT	06/01/2014		Theseus	CJIT	CJIT worker B attempted to call Michael but not answered.		
Boots Pharmacy	07/01/2014		Store Manager	Boots Pharmacy █████ █████ Bristol	New contract signed to supply supervised medication		
AWP Bristol CJIT	08/01/2014		Theseus	CJIT TO RSI Housing	Telephone call to RSI housing by CJIT worker. He has also lost contact with Michael and has been trying to find him as his Home Choices has been accepted. Related that Michael had set hob alight accidentally. This is being investigated but is not recorded as his fault although Fire Brigade stated that he was very sedated. RSI Housing stated that he will set up floating support when Michael moves as he is a vulnerable adult.		
S.Glos Clinical Commissioning Group	10/01/2014		GP Record	GP Practice 1	Michael seen by GP12 who records Michael asking for sick note and zopiclone. Med3 issued 10/1 to 10/3 "Drug dependence".		
AWP Bristol CJIT	13/01/2014		Theseus	CJIT	CJIT home visit: Home visit by CJIT Worker B with Worker C, due to inability to contact Michael by phone. Michael was in and agreed to come to another appointment. Appointment was made and then changed to later date 23.1.2014.		
S.Glos Clinical Commissioning Group	16/01/2014		GP Record	GP Practice 1	Copy of note from Jobcentre plus sent to Michael stating that they did not accept photocopies of Fit Notes (Med3) and telling him to ask for a new one dated from 10/01/14		

S.Glos Clinical Commissioning Group	16/01/2014		GP Record	GP Practice 1	Admin note by GP11. Michael recorded as reporting loss of Med 3, duplicate had been reissued and signed by GP but not accepted by JCP. New Med 3 issued 10/1 to 10/3 "Drug dependence"		
S.Glos Clinical Commissioning Group	17/01/2014		GP Record	GP Practice 1	Michael seen by GP9 who records Michael not yet seen by BDAS. Blue script recorded as issued.		
Bristol Drugs Project	18/01/2014		Theseus needle exchange database	BDP Engagement Team	*"Suggested he comes back to the info session today as he says he really needs to get on top of using, please check and encourage to come along"*		
AWP Bristol CJIT	23/01/2014		Theseus	CJIT	CJIT Follow-up appointment: Attended appointment. Motivation mapping work done on 'me today' and 'positives and negatives of drug use'. Michael stated that he had now had his prescription increased and could address on top use. Identified that he needs to take action as he is doing nothing constructive. Michael previously attended Narcotics Anonymous in [redacted] and wants to return to meetings once he feels more stable. Discussed Princes Trust and at next appointment we planned to set up meeting with someone at Princes Trust with view to a referral at a mutually agreed date once Michael felt more stable.	Michael felt that he needed to take some action himself including attending meetings once he feels more stable. NA and AA list given to Michael. Given appointment to attend BDP information session to look at treatment options. Princes Trust referral agreed post stabilisation. Michael to ask GP for gym referral	
Avon and Somerset Police	24/01/2014		PNC:13/233778D CRO: 72429/13L	Avon & Somerset Constabulary	Possessing Controlled Drug - Class B - Other	Cautioned.	
AWP Bristol CJIT	31/01/2014		Theseus	CJIT	CJIT Follow-up appointment: Michael did not attend.		

S.Glos Clinical Commissioning Group	31/01/2014		GP Record	GP Practice 1	Michael seen by GP9 who records that Michael reported that his brother in law had died in █████, was very distressed and used heroin and crack. Michael reported as wanting to "get back on straight as he was feeling much better. Discussion and GP9 agreed to one week prescription of diazepam to help get Michael off heroin and crack - had helped in the past.		
Bristol City Council Housing Advice Team	Feb 2014				Michael was placed on the Council's Priority Move-On Scheme which allowed to him to bid for properties advertised through HomeChoice Bristol as a priority case.		
Boots Pharmacy	04/02/2014		PMR	Boots Pharmacy ███ ███████ Bristol	DISPENSED – ZOPICLONE 7.5 mg and METHADONE 1mg/1ml Oral Solution SF (60mls daily) Daily collection until 07/03/2014		
S.Glos Clinical Commissioning Group	04/02/2014		GP Record	GP Practice 1	Michael seen by GP12 who records Michael reporting brother had died the previous week in █████ from heart trouble and had not picked up his methadone for past 3 days so pharmacy would not dispense. Recorded that Michael said he had used heroin again, was low in mood and struggling to sleep. Blue script issued. GP12 advised Michael to see regular Dr and stop heroin.		
S.Glos Clinical Commissioning Group	11/02/2014		GP Record	GP Practice 1	Michael recorded as not attending health care assistant appointment.		

S.Glos Clinical Commissioning Group	18/02/2014		GP Record	GP Practice 1	Michael seen by GP12 who records "doing better…. says no relapses". Blue script recorded as issued.		
S.Glos Clinical Commissioning Group	21/02/2014		GP Record	GP Practice 1	Michael seen by GP13 who records Michael reporting a rear shunt 2 days earlier and on examination finds whiplash injury. GP13 refers Michael for physiotherapy.		
AWP Bristol CJIT	21/02/2014		Theseus	CJIT	Telephone call to Michael. He says he is at doctors. Stated that he was in a car accident and could not move his neck. Explained that he had missed last appointment due to the death of his brother. Requested new appointment.	For next appointment - planned to revisit goal planning and to refer into another service as CJIT service provision is changing at end of March.	
S.Glos Clinical Commissioning Group	04/03/2014		GP Record	GP Practice 1	Michael seen by GP12 who records Michael reporting that he was doing okay, mother due to visit. Blue script recorded as issued.		
Bristol Drugs Project	04/03/2014 - 01/04/2014		Theseus needle exchange database	BDP Engagement Team	3 visits to needle exchange recorded		

S.Glos Clinical Commissioning Group	05/03/2014		GP Record	GP Practice 1	Michael seen by GP9 who records "In a mess again, Mum coming over, using crack ++ and heroin. GP9 records advising Michael that he should stop prescribing methadone if still using on top. Michael recorded as saying he is more focussed and will stop. GP9 agreed to issue prescription for diazepam to help get through stopping drugs. Records that Michael understood that the methadone prescriptions would stop if he continued to use on top as he is at risk of overdose.		
AWP Bristol CJIT	06/03/2014		Theseus	CJIT	CJIT follow-up appointment: Michael did not attend his appointment. Have called and left message.	Had planned to do relapse prevention mind mapping, TOPS and complete mutual aid goals.	

AWP Bristol CJIT	10/03/2014		Theseus	CJIT	CJIT required Assessment appointment:CJIT worker C saw Michael for a Required Assessment at Police Station following testing positive for opiates following arrest for shop theft.Michael had been out of contact with CJIT as his brother had died. He stated that he had had problems getting a passport and missed the funeral and had been feeling very low. Denies any suicidal ideation and stated that although he has self-harmed in past, would not do that now. Client states he has not used any illicit substances in past few days, but was injected both crack and heroin 'as much as I can get my hands on' on top of his 60mg methadone prescription. States he does drink sometimes, and when he does it can be up to 10 cans of tenants. States he has just been prescribed one weeks' worth of diazepam from his GP, he reports he is struggling to sleep after the recent death of his brother. Discussed risk of snowballing in terms of overdose and risks of high level polydrug use particularly in combination with prescribed medication. Risks of cocaethylene discussed. Client states he is trying to alternate between injecting and smoking. Discussed risk of sharing works – he states he does not know if he has shared since his last test. Discussed re-testing and he said he would like to think about it but feels he probably should. Stated he was funding his drug use by 'this and that'. Client stated he had no phone as his ex-partner stole it, he asked if CJIT worker B would be able to write to him with a new appointment	Client on CJIT caseload so reviewed care plan and risk and completed DIR and emailed keyworker. Risks Client feeling low and struggling to sleep following his brother's death. Discussed counselling for bereavement.	Risk screen identified risks around drug use and associated behaviours. No 'risk from others' identified.
Boots Pharmacy	10/03/2014		Store manager	Boots Pharmacy	Michael received a banning letter from the store after being seen shoplifting. The police were called & Michael arrested.	Case was heard [redacted] [redacted] [redacted] Michael pleaded guilty & given a	

						conditional discharge for 12 months.	
S.Glos Clinical Commissioning Group	10/03/2014		GP Record	GP Practice 1	Michael seen by GP12 in duty Dr surgery. GP12 records Michael reporting no on top use since last seen but using double dose of zopiclone. Zopiclone reduction discussed. Med 3 issued 10/3 to 10/5 "Drug dependence"		
S.Glos Clinical Commissioning Group	17/03/2014		GP Record	GP Practice 1	Michael seen by GP12 in duty Dr surgery. Michael advised to attend normal surgery in future to allow better follow-up. Blue script recorded as issued.		
Boots Pharmacy	from 17/03/2014 until 24/7/14	Daily	PMR & handwritten note	Boots Pharmacy	Allowed back into store. Prescriptions MDA for Methadone 1mg/ml Oral Solution (60mls) daily dose supplied NB.08/05/2014 handwritten letter from Michael authorising his friend to collect on his behalf for that day.		
S.Glos Clinical Commissioning Group	31/03/2014		GP Record	GP Practice 1	Report of Michael not attending physiotherapy appointment received by practice.		

S.Glos Clinical Commissioning Group	31/03/2014		GP Record	GP Practice 1	Michael seen by GP14 who records Michael saying he is living in temporary accommodation; not engaged with any services; only using crack and heroin once a week; had developed abscess from injecting; on waiting list for BDP; unsupervised consumption. GP14 records telling Michael she did not feel unsupervised consumption was appropriate but agreed to issue 1 week blue script while she discussed the matter with BDP practitioner 1. GP14 records the view that she believes Michael is using much more than he admits to and advised him to stick to one or two doctors to ensure continuity.		GPs repeatedly record trying to get Michael to book into normal surgery times with the same one or two doctors to enable continuity but he continues to use open access/duty doctor appointments which are shorter and therefore not suitable for review of drug problems or continuity of care which the practice promotes for all patients.
S.Glos Clinical Commissioning Group	31/03/2014		GP Record	GP Practice 1	GP14 records conversation with BDP practitioner 1 who confirmed Michael is on the waiting list for BDP and agreed that he should be on supervised consumption. GP14 arranged and wrote a letter to Michael to explain and offered to discuss if he wished.		

AWP Bristol CJIT	02/04/2014		Theseus	CJIT TO BDP	Michael to be discharged from CJIT. Discharge Plan. Michael to engage with Bristol ROADS as per care plan. Telephone call made to BDP shared care to clarify whether Michael has been referred by GP to Shared Care as he always states that he has been referred and yet has not been seen by a Shared Care Worker.	New criteria for staying on CJIT caseload is 2-4 weeks only. As Michael open to Bristol ROADs Shared Care & has been referred for Preparation group, TC made to Shared Care to raise awareness that client states he has not yet been seen.	New criminal justice commissioning arrangements from April 2014.
Bristol Drugs Project	02/04/2014		Theseus database / client file	BDP Shared Care Team	Referral from CJIT to Shared Care team		Michael had not engaged with service following referral to BSDAS, so treatment had remained "GP led", albeit with significant supportive input from CJIT
Avon and Somerset Police	02/04/2014		PNC:13/233778 D CRO: 72429/13L	Avon & Somerset Constabulary	Theft - Shoplifting (cosmetics) - Charged	Attended [redacted] Magistrates Court - Guilty: - Conditional Discharge for 12 months -Costs of £85.00 -V/S of £15.00	
AWP Bristol CJIT	04/04/2014		Theseus	CJIT	Worker D CJIT IN [redacted] Magistrates Court reported that Michael had been given a conditional discharge.		

S.Glos Clinical Commissioning Group	07/04/2014		GP Record	GP Practice 1	Michael seen by GP15 in a duty doctor slot. GP15 records Michael saying he is not using on top but she also notes that he had previously been told that his methadone script would be stopped if he was using on top. Recorded use of duty slot and different doctor again.		
AWP Bristol CJIT	09/04/2014		Theseus	CJIT Discharge Plan	CJIT appointment. Discharge plan: to attend ROADS for key working and recovery support as discussed at appointments and engage with BSDAS Change Shared Care.		It is not clear from the records if Michael attended this appointment.
Bristol Drugs Project	15/04/2014		Theseus needle exchange database	BDP Engagement Team	"*asked about Hep C testing, please let him know we can offer dry blood spot testing when he comes in*"		
AWP Bristol CJIT	22/04/2014		Theseus		Transferred to shared care		
S.Glos Clinical Commissioning Group	23/04/2014		GP Record	GP Practice 1	GP15 records admin note of telephone call from support worker asking for a prescription for Michael because he had run out of methadone 2 days earlier.		
S.Glos Clinical Commissioning Group	30/04/2014		GP Record	GP Practice 1	Letter sent to Michael by practice because he had not responded to several letters offering physiotherapy appointment. Offered opportunity for him to discuss this. Also asked for up to date telephone and/or email contact details.		
S.Glos Clinical Commissioning Group	07/05/2014		GP Record	GP Practice 1	Michael seen by GP16 who records Michael "denies illicit substances and understands he should see his usual doctor" GP16 asked GP11 to issue blue script.		

S.Glos Clinical Commissioning Group	07/05/2014		GP Record	GP Practice 1	GP11 records speaking to Michael and advising him to book with usual doctor. Records Michael's intention to book with GP12 in 2 weeks. Supervised/unsupervised discussed. Blue script recorded as issued.		
Avon and Somerset Police	09/05/2014		Assist: AS-20140509-0031	Avon & Somerset Constabulary	Call received from Michael reported his ex-partner, ■ has stormed out of the flat taking his IPhone and other items that belong to him. He informs operator that ■ constantly texts, calls, stalks or harasses him. Michael is not expecting him to return.	Officers made numerous attempts to contact Michael, via phone, text and leaving voicemails, and also in person but he is refusing to engage with officers. Following attempts and no violence disclosed, Filed.	
S.Glos Clinical Commissioning Group	20/05/2014		GP Record	GP Practice 1	Michael seen by GP6 who records "on methadone, off all drugs, still waiting for BDP, unsupervised". GP6 arranged to check details with BDP. Blue script recorded as issued. Med3 issued 07/5 to 05/8 "Drug dependence"		
S.Glos Clinical Commissioning Group	20/05/2014		GP Record	GP Practice 1	Telephone call from Pharmacy 3 to GP6 reported that Michael has already had methadone issued that morning and had then brought in new blue script. GP6 recorded that next blue script was due to start on 4th June.		

Avon and Somerset Police	22/05/2014		Assist: AS-20140522-0064	Avon & Somerset Constabulary	Michael called in to report he had been raped by an ex-boyfriend and his friend. Stated one of them in the flat with him. Michael sounds possibly drunk and keeps leaving the line, not answering. Operator put on Hold. Disclosed happened approx. 10 months ago. He informs operator that the offender has just left, does not want officers to attend.	Officers attend for welfare check, as Operator concerned. Michael spoken with outside of the flat, no one present in the flat. His appearance suggested heavily under influence of drink/drugs . Confirmed nothing happened this evening, but historically. Will make a decision if he is going to report and will attend a Station. Refused to confirm crime or further details.	
S.Glos Clinical Commissioning Group	04/06/2014		GP Record	GP Practice 1	Michael seen by GP11 who records request from benefits agency for Med3 from 21/5, letter seen. Reports Michael asking for blue script and saying he felt it should be unsupervised consumption. GP11 reviewed past notes and records advising Michael that supervised had been advised by BDP until seen by them. GP11 was unhappy that she couldn't be clear about what was happening in Michael's life, she contacted single point of entry, [redacted] and [redacted] who all said they did not have an open referral for Michael. GP11 left a message for BDP asking to speak to BDP practitioner 1. Blue script recorded as issued and next due date recorded as 18/06/14		Evidence that GP11 was trying to ensure consistency of approach to stabilise Michael's care.

S.Glos Clinical Commissioning Group	05/06/2014		GP Record	GP Practice 1	GP11 telephone conversation with BDP practitioner 2 who advised that Michael was on her waiting list, should have supervised consumption and urine samples for drug screening.		
S.Glos Clinical Commissioning Group	05/06/2014		GP Record	GP Practice 1	GP11 records that she left a phone message for Michael confirming that he was on the BDP waiting list		
S.Glos Clinical Commissioning Group	16/06/2014		GP Record	GP Practice 1	GP8 records phone call from Places for People support worker who reported that Michael was using Class A drugs, needles and spoons found at his home, concerned about Michael's physical wellbeing and reported that Michael was at risk of eviction as he was not engaging with the moving process.		
S.Glos Clinical Commissioning Group	18/06/2014		GP Record	GP Practice 1	GP15 records telephone call made to BDP for advice as blue script due but Michael reported to be using class A drugs. Daily supervised methadone advised. Blue script recorded as issued.		
S.Glos Clinical Commissioning Group	26/06/2014		GP Record	GP Practice 1	BDP practitioner 2 records sending Michael details of an appointment with BDP shared care on 10/7 and asked the practice to remind him if they saw him.		
Bristol City Council Housing Advice Team	July 2014				Michael was removed from the was removed from the Council's Priority Move-On Scheme in July 2014 after he failed to place enough bids for suitable properties		

S.Glos Clinical Commissioning Group	02/07/2014		GP Record	GP Practice 1	GP1 records telephone call from support worker stating that Michael's blue script had run out and requesting another. GP1 records that as he did not know the support worker or patient then the patient would need to be seen.		
S.Glos Clinical Commissioning Group	02/07/2014		GP Record	GP Practice 1	Michael seen by GP1, attended alone. Recorded as stable on 60ml methadone and still taking 15mg zopiclone. "Given 2 weeks daily pick up methadone" blue script. Awaiting BDP appointment advised "must be seen fortnightly in the interim". GP1 booked appointment with GP12 on 15.07.14		
Bristol Drugs Project	09/07/2014		Theseus needle exchange database	BDP Engagement Team	"Interested in doing Naloxone training"		
Bristol Drugs Project	10/07/2014		Theseus database / client file	BDP Shared Care Team	DNA assessment appointment at Health Centre		
S.Glos Clinical Commissioning Group	10/07/2014		GP Record	GP Practice 1	BDP Practitioner 2 records Michael did not attend appointment - no reason and no contact. Further appointment arranged for 24/07/14. 8 day blue script recorded as issued for pharmacy 3		

S.Glos Clinical Commissioning Group	15/07/2014		GP Record	GP Practice 1	Michael seen by GP12 who records problem title "Anxiety with depression". Michael is reported as saying he had a long history of psychiatric problems and had been treated with mirtazapine (antidepressant), pregabalin (used to treat generalised anxiety disorder) and quetiapine (anti-psychotic used in the treatment of depression). Also recorded as saying he had 4 admissions to Psychiatric hospital for suicidality. Michael recorded as having lower mood for several months, some self-harm (cutting arms) but denies current suicidality. Low mood started after death of brother and now stressed because of risk of eviction. Michael is recorded as asking for a letter about psychiatric problems for housing. GP 12 prescribed mirtazapine to treat Michael's anxiety and depression		1. Michael was seen in a routine surgery appointment which appears to have enabled him to discuss his mental state more fully than in his usual choice of open access appointments. He had a reason to discuss this in light of housing concerns. This appointment had been booked for him by GP1. 2. GP practice 1 did not have any medical records from Dr in [redacted]. There is no system for automatic transfer of medical records from outside UK NHS Primary Care.

S.Glos Clinical Commissioning Group	15/07/2014		GP Record	GP Practice 1	Letter written by GP12 to confirm that Michael had reported a past psychiatric history that he was being treated for opiate drug dependency and was suffering from stress. GP12 states that Michael was a vulnerable adult and that the housing situation would add considerably to his stress.		
S.Glos Clinical Commissioning Group	15/07/2014		GP Record	GP Practice 1	Admin letter sent by GP Practice 1 to Dr in ████ requesting copy of Michael's past medical records		
Bristol Drugs Project	18/07/2014; 22/07/2014		Theseus needle exchange database	BDP Engagement Team	2 visits to needle exchange recorded		
Avon and Somerset Police	18/07/2014		Guardian: 73144/14	Avon & Somerset Constabulary	Victim, Michael was sunbathing with his partner in a Park in Bristol, when at some point an unknown offender has snuck up and stolen his bag.	Filed 18/07/14. No CCTV, No Witnesses. Victim unaware at the time the theft had occurred.	
Solon Housing	21/07/2014				There is correspondence between Solon and Places for People around Michael’s non engagement including several letters, visits and warnings. Following the RSI procedure for non-engagement, Notice Requiring Possession was served on 21st July 2014.		
Bristol Drugs Project	24/07/2014		Theseus database / client file	BDP Shared Care Team	Assessment completed, including risk assessment & TOPS form	OST dose titration undertaken and Michael taken onto caseload	
S.Glos Clinical Commissioning Group	24/07/2014		GP Record	GP Practice 1	Letter received by GP Practice 1 from Dr in ████ stating that Michael had not been seen by them since September 2012 and that Michael's consent was required before any records could be forwarded.		It is the author's understanding that unlike the UK NHS, the medical system in ████ does not have a mechanism which

							automatically ensures any transfer of medical records in primary care.
S.Glos Clinical Commissioning Group	24/07/2014		GP Record	GP Practice 1	Michael seen by BDP practitioner 2. Dose of methadone up-titrated in light of on top usage.		
S.Glos Clinical Commissioning Group	25/07/2014		GP Record	GP Practice 1	Admin note that copy of medical records sent to solicitor.		This episode appears to relate to a whiplash injury sustained by Michael
S.Glos Clinical Commissioning Group	30/07/2014		GP Record	GP Practice 1	GP11 reports receipt of message from Pharmacy 3 stating that Michael had not collected methadone since 24/7. Longest gap. Discussed with BDP practitioner who advised Michael should be seen and reassessed.		
Boots Pharmacy	30/07/2014		PMR	Boots Pharmacy	PMR entry states ''Patient has not collected since 24/7/2014." Rx ended 29/07/2014.	surgery Informed	
Boots Pharmacy	30/07/2014		Store manager	Boots Pharmacy	No further contact until OCTOBER 2014		

S.Glos Clinical Commissioning Group	06/08/2014		GP Record	GP Practice 1	Michael seen by GP1 and recorded as saying his father had died in [redacted], Michael was unsure of the details but thought it may be alcohol related. Recorded as very distressed, " visibly shaky, sweaty". Had had supervised methadone earlier that day. Given prescription for very short term supply of diazepam to help with acute bereavement reaction, advised about risk of addiction.		Benzodiazepines such as diazepam have a high risk of dependency with ongoing usage. Short term use as an acute anxiolytic is common and does not in general lead to dependency in isolation.
S.Glos Clinical Commissioning Group	07/08/2014		GP Record	GP Practice 1	BDP practitioner 2 records Michael did not attend appointment - no reason and no contact. Further appointment arranged for 21/08/14. No blue script issued. Telephone call to pharmacy 3 showed that Michael had not had methadone dispensed by them since 24/7. He was on 7 day script for daily supervised consumption. Concerned that it was not known where and if Michael was getting methadone.		
Bristol Drugs Project	07/08/2014		Theseus database / client file	BDP Shared Care Team	DNA appointment at HC	OST treatment interrupted	Michael had not been collecting daily dose from pharmacy and so treatment had been interrupted prior to missed appointment. Attempts to contact Michael by phone unsuccessful.

S.Glos Clinical Commissioning Group	08/08/2104		GP Record	GP Practice 1	Michael is recorded by GP1 as arriving at the practice without an appointment asking for blue script. GP1 states that in light of BDP practitioner 2 concerns, Michael was advised that he must contact practitioner. Blue script not issued.		
Bristol Drugs Project	12/08/2014		Theseus database / client file	BDP Shared Care Team	Michael contacted via BDP Advice Centre	Harm Reduction advice given and telephone conversation with Shared Care worker facilitated	Appointment arranged to re-start treatment for 13.08.14
Bristol Drugs Project	13/08/2014		Theseus database / client file	BDP Shared Care Team	DNA appointment at HC	Plan made with GP for interim treatment if Michael attended surgery before next appointment - already scheduled for 21.08.14	Michael had attended surgery on 08.08.14 (without an appointment) where GP had declined to re-start OST without Michael seeing a drug worker for re-assessment.
S.Glos Clinical Commissioning Group	13/08/2014		GP Record	GP Practice 1	BDP practitioner 2 records Michael did not attend appointment. Had spoken to Michael the previous evening about missed appointment and recent bereavement. No contact or reason for missed appointment. Plan written in record for GP.		
S.Glos Clinical Commissioning Group	14/08/2014		GP Record	GP Practice 1	Michael seen by GP4. Clear plan noted.		
S.Glos Clinical Commissioning Group	21/08/2014		GP Record	GP Practice 1	Michael attended BDP appointment. Dose titration arranged. Blue script recorded as issued for pharmacy 4.		

Bristol Drugs Project	21/08/2014		Theseus database / client file	BDP Shared Care Team	Appointment at HC - attended	Care plan revisited & OST dose titration re-started	Treatment had begun via GP as per plan of 13.08.14
Bristol City Council Housing Advice Team	September 2014				In September 2014, Michael was referred to the Housing Advice Team again by Places for People as the owner of the building wanted to obtain possession of Michael's flat. However, it does not appear that any further action was taken in regard to the eviction.		
Bristol Drugs Project	04/09/2014		Theseus database / client file	BDP Shared Care Team	DNA appointment at HC	Message left with pharmacy - who confirmed daily collection of medication - that treatment would continue until next scheduled appointment on 18.09.14	
S.Glos Clinical Commissioning Group	04/09/2014		GP Record	GP Practice 1	BDP practitioner 2 records that Michael did not attend appointment. BDP practitioner spoke to pharmacy 4, Michael had been attending daily but not yet that day. Blue script recorded as issued but asked pharmacy to reinforce message attached to prescription for Michael that non-attendance would mean a reduction prescription next time.		
Bristol Drugs Project	09/09/2014		Theseus needle exchange database	BDP Engagement Team	Needle exchange recorded		

S.Glos Clinical Commissioning Group	12/09/2014		GP Record	GP Practice 1	Michael seen by GP12. Recorded as doing well with BDP. Med 3 issued 20/8 to 19/11 "Opioid type drug dependence". Zopiclone and antidepressant medication prescription issued.		
S.Glos Clinical Commissioning Group	12/09/2014		GP Record	GP Practice 1	GP17 records an evening telephone request from Michael at 18:27 for a blue script. Script printed but Friday evening and surgery now closing. Controlled drug scripts cannot be faxed so unable to ensure weekend supply of methadone.		
S.Glos Clinical Commissioning Group	18/09/2014		GP Record	GP Practice 1	Michael attended BDP appointment with BDP practitioner 2. Discussed harm reduction in terms of shared needles and blood borne viruses, safe sex with advice around risk of transmission of blood born viruses between gay partners. Reported that Michael was thinking of going to [redacted] to see his mother and advised that proof of travel would be needed to enable methadone supply.		
Bristol Drugs Project	18/09/2014		Theseus database / client file	BDP Shared Care Team	Appointment at HC - attended	Treatment Outcome Proforma (TOP) review completed during session	
Bristol Drugs Project	22/09/2014; 30/09/2014		Theseus needle exchange database	BDP Engagement Team	2 needle exchanges recorded		

S.Glos Clinical Commissioning Group	24/09/2014		GP Record	GP Practice 1	Admin note of Medication review for Michael undertaken by pharmacy. Sip feed prescription needs reviewing. MUST score (Malnutrition Universal Screening Tool) and advice re diet issued by practice.		
S.Glos Clinical Commissioning Group	26/09/2014		GP Record	GP Practice 1	GP18 records telephone call from Michael's support worker to request medication. Antidepressant dose increased.		
S.Glos Clinical Commissioning Group	02/10/2014		GP Record	GP Practice 1	BDP appointment cancelled by BDP practitioner 2. Request and instructions sent to GP4 for blue script.		
Bristol Drugs Project	02/10/2014		Theseus database / client file	BDP Shared Care Team	Appointment re-arranged by BDP - re-scheduled to 16.10.14		
S.Glos Clinical Commissioning Group	06/10/2014		GP Record	GP Practice 1	Michael seen by GP14 who records review of medication. Reports reminding Michael of date of next BDP appointment on 16/10.		
Avon and Somerset Police	11/10/2014		Guardian: 105522/14	Avon & Somerset Constabulary	Michael is a mentioned party in a Robbery of personal property.	Filed. Michael failed to engage with police.	
Avon and Somerset Police	15/10/2014		Assist: AS20141015-0958	Avon & Somerset Constabulary	Member of the public called ambulance as a male unconscious on the floor. Male: Michael.	Treated by Ambulance. Michael had taken: Methadone, Date Rape drug called 'G' which has been self-prescribed. Also has taken 'crack'. Ambulance dealing no further police action.	
Bristol Drugs Project	16/10/2014		Theseus database / client file	BDP Shared Care Team	DNA appointment at HC		Michael phoned surgery to notify inability to attend. Explanation was that he had taken

							un-named partner to hospital to seek treatment on an injured ankle, the injury occurring previous day when partner had fallen down some stairs "during an argument"
S.Glos Clinical Commissioning Group	16/10/2014		GP Record	GP Practice 1	Michael recorded as ringing to cancel BDP appointment as partner had fallen downstairs and taken him to A&E. BDP practitioner 2 had spoken to colleague who works with partner. DV had been discussed. Blue script recorded as issued.		
Boots Pharmacy	22/10/2014		PMR	Boots Pharmacy	Returns with Prescription MDA Methadone 1mg/ml Oral Solution -dose now 85mls.		
Boots Pharmacy	22/10/2014		PMR	Boots Pharmacy	ENTRY ON PMR ‘’checked with previous pharmacy. Pt did not pick up from them on Monday and just missed the first dose on this Rx		
S.Glos Clinical Commissioning Group	30/10/2014		GP Record	GP Practice 1	Michael seen by GP3 who records MUST score of 0, weight 77kb, BMI 24.3, no indication for sip feeds. Michael reports RTA, passenger in a low speed shunt 2 weeks earlier and complaining of neck and back pain. Referred for physiotherapy.		
Boots Pharmacy	03/11/2014		PMR	Boots Pharmacy	Last date of collection of methadone from Boots. Prescription dated until 09/11/2014 - 6 days supply was uncollected.		
Boots Pharmacy	03/11/2014		store manager	Boots Pharmacy	NO FURTHER CONTACT		

S.Glos Clinical Commissioning Group	04/11/2014		GP Record	GP Practice 1	Telephone call received by GP15 from pharmacy 5 checking whether blue script was correct - GP15 confirmed it was		
Boots Pharmacy	from 4/11/14 until 17/11/2014 and then 11/02/2015 to 23/3/15	Daily	Store Manager & Pharmacist, with reference to Pharmacy PMR	Boots Pharmacy	4/11 to 17/11/14 Supervised daily supplies of 85mls Methadone Oral solution. Prescriber = [redacted] from [redacted] Health centre. From 11/2/15 daily supply increased to 95mls		
Bristol Drugs Project	13/11/2014		Theseus database / client file	BDP Shared Care Team	DNA appointment at HC	Call to pharmacy revealed that previous prescription had been taken not to local pharmacy but to one in [redacted].	Message left at pharmacy (where established that attendance had been regular) suspending dosage as of 14.11.14 and urging Michael to contact BDP urgently.
S.Glos Clinical Commissioning Group	13/11/2014		GP Record	GP Practice 1	BDP Practitioner 2 records Michael did not attend appointment. Phone hung up repeatedly when she tried to ring Michael. I Spoke to pharmacy 5, Michael had been collecting daily apart from one day. Thought it likely Michael was staying near pharmacy 5 as is a long way from home address. Pharmacy asked to issue that day's dose and then suspend dispensing until he has been reviewed by BDP.		
Bristol Drugs Project	14/11/2014		Theseus database / client file	BDP Shared Care Team	T/C to Michael	Discussed need for treatment to be in Bristol area in order to continue from same surgery	Michael explained that had been staying with new partner in s.glos area. He under-

							stood that GP required treatment to be delivered in Bristol and that scripting would continue with daily supervised consumption at pharmacy (Michael's preferred pharmacy)
Solon Housing	14/11/2014				An order for possession was given on 14th November 2014. We were unable to get hold of Michael during this time and believe he abandoned the property.		
Bristol Drugs Project	17/11/2014		Theseus database / client file	BDP Shared Care Team	Treatment re-commenced with Michael collecting prescriptions from surgery	Next appointment arranged for 11.12.14	
S.Glos Clinical Commissioning Group	17/11/2014		GP Record	GP Practice 1	BDP Practitioner 2 records conversation with Michael. New partner living in South Glos. BDP advised need for use of local pharmacy so any problems could be resolved easily. Arrangement made at Michael's request for prescription to be dispensed by pharmacy 4		
S.Glos Clinical Commissioning Group	21/11/2014		GP Record	GP Practice 1	Michael seen by GP17 who records late prescription request, ongoing pain from RTA and feeling "everything getting on top of him". Antidepressant dose increased.		
Bristol Drugs Project	21/11/2014		Theseus needle exchange database	BDP Engagement Team	Needle exchange recorded		
Bristol Drugs Project	11/12/2014		Theseus database / client file	BDP Shared Care Team	DNA appointment at HC		

Bristol Drugs Project	17/12/2014; 22/12/2014; 24/12/2014		Theseus needle exchange database	BDP Engagement Team	3 needle exchanges recorded		
S.Glos Clinical Commissioning Group	05/12/2014		GP Record	GP Practice 1	Telephone call between GP17 and Michael, reports death of his mother "under suspicious circumstances", ongoing police investigation. Michael recorded as saying his mother lived with a violent partner. Lost hand luggage at airport which contained medication and mobile phone. Recorded as "shaky and distressed" Medication issued and grief counselling offered at a future date. Replacement medication prescription issued, methadone not issued as already at pharmacy 4.		
S.Glos Clinical Commissioning Group	08/12/2014		GP Record	GP Practice 1	Michael seen by GP12 who records discussion about bereavement. Also reported as saying ex-partner was stalking him and flat broken into and mirtazapine, zopiclone and diazepam stolen. GP12 issued further 2 weeks supply of these. Med 3 issued 19/11 to 18/2 "Opioid type drug dependence. Bereavement"		
S.Glos Clinical Commissioning Group	11/12/2014		GP Record	GP Practice 1	BDP practitioner 2 records Michael did not attend appointment - no reason and no contact. Blue scripts recorded as issued but left with GP practice in light of recent events.		

S.Glos Clinical Commissioning Group	07/01/2015		GP Record	GP Practice 1	Michael seen by BDP practitioner 3 (covering for BDP 2) who records Michael requesting that partner attend with him BDP 3 agreed but advised Michael that he would need to check with BDP 2 for future encounters. Record of discussion of coming off opiates and using crack and vodka to support withdrawal seeking increase in methadone dose. BDP practitioner 3 made her views very clear. Michael recorded as wanting to change pharmacy to Kingswood area, partner suggested pharmacy 5. BDP 3 advised discussion with BDP 2. New dose agreed safety concerns around overdose with on top usage of drugs and alcohol recorded as being discussed and blue script recorded as issued for pharmacy 4.		
Bristol Drugs Project	08/01/2015		Theseus database / client file	BDP Shared Care Team	Appointment at HC - attended		Appointment was with covering Senior practitioner. Michael requested that partner (Dan) be allowed to sit in on appointment. This was allowed.
Avon and Somerset Police	13/01/2015		Guardian: 4325/15	Avon & Somerset Constabulary	Michael and Dan had a verbal argument in the morning and Michael left the address to see a friend. Dan contacted Michael's mother, which caused annoyance to Michael and parties then exchanged text messages during which Dan requested Michael collect his personal belongings.	Filed 22/01/15. No threats made. Michael refused to engage with police. DASH: DV Medium. Lighthouse tagged for support referrals if required.	

Solon Housing	15/01/2015				Worker attended the property on 15th January with a Court bailiff to change the locks. There were many used needles left at the property (Pictures sent to chair)		
Bristol Drugs Project	16/012014; 28/01/2014; 31/01/2014		Theseus needle exchange database	BDP Engagement Team	3 needle exchanges recorded		
Solon Housing	18/01/2015				His official tenancy end date with Solon is 18/01/2015		
Bristol City Council Housing Advice Team	18/01/2015				Michael left of his own volition on 18th January 2015, stating that he was going to live with his partner. This was not a planned move.		
S.Glos Clinical Commissioning Group	30/01/2015		GP Record	GP Practice 1	Notification received by practice stating that Michael did not attend physiotherapy appointment and was therefore discharged from the service. Further referral request would be needed if clinically indicated.		

S.Glos Clinical Commissioning Group	05/02/2014		GP Record	GP Practice 1	Michael seen by BDP practitioner 2 who records that he attended "with partner who is a non-drug user" BDP practitioner 2 recorded that "in my opinion there is control issues within the relationship but partner did agree to leave the session when I asked. I spoke with Michael, they do argue and last night Michael left and went to stay with ex-partner. Michael reports being slapped and 'almost strangled' by partner, I have talked through options of safety with Michael but he would like to stay and try to make relationship work". BDP Practitioner 2 arranged to see Michael again and then to transfer his care to South Glos services as he was now resident there. Blue script recorded as issued for pharmacy 6		
Bristol Drugs Project	05/02/2015		Theseus database / client file	BDP Shared Care Team	Appointment at HC - attended		Attended with partner (Daniel). Daniel stayed for much of session but agreed to leave when asked to do so by worker. Worker recorded "in my opinion there is control issues within the relationship but partner did agree to leave the session when I asked. I spoke with Michael; they do argue and last

							night Michael left and went to stay with ex-partner. Michael reports being slapped and 'almost strangled' by partner, I have talked through options of safety with Michael but he would like to stay and try to make relationship work".
Bristol Drugs Project	09/02/2015		Theseus needle exchange database	BDP Engagement Team	Needle exchange recorded		
Bristol Drugs Project	10/02/2015		Theseus database / client file	BDP Shared Care Team	T/C from Michael notifying us of problem with his prescription	Attempt to contact pharmacy made	
S.Glos Clinical Commissioning Group	11/02/2014		GP Record	GP Practice 1	GP11 records a conversation with BDP practitioner 2 who reported that Michael had lost yesterday's prescription, she had checked with pharmacy and script had not been presented. New blue script recorded as issued - instructions to omit 10/02 dose.		
S.Glos Clinical Commissioning Group	16/02/2015		GP Record	GP Practice 1	Report received from MIU about an attendance by Michael as a result of a hand injury reportedly sustained when he had punched a wall a week earlier. Fracture recorded.		

Sirona Care and Health	16/02/2015	11.06	Minor Injury Unit	Sirona Care and Health	Michael' attended with a right hand injury. Injury sustained 1 week prior by punching a wall. Methodone and mertazipine noted as current medication. X ray showed fracture 5th metacarpel with angulation.	Plaster of paris applied. Referred to plastics trauma clinic at NBT the next day. Discharge letter sent to GP. This included the standard phrase 'No Safeguarding Concerns'.	
Bristol Drugs Project	16/02/2015		Theseus needle exchange database	BDP Engagement Team	Needle exchange recorded		
North Bristol NHS Trust	17/02/2015	N/A	Medical Record	North Bristol NHS Trust Department of Plastic Surgery	Michael was referred to the Department of Plastic Surgery from the Minor Injuries Unit. Michael reported he had punched a wall 9 days previous. He was suffering from fracture to the right Metacarpal shaft. Treatment was a plaster of Paris cast.	Referred to the Hand Service and for physio.	Staff acted appropriately
AWP Bristol CJIT	18/02/2015		Theseus	Referral to BSDAS	Referral to BSDAS from shared care for Specialist Prescribing. On 95mg methadone daily supervised consumption, but using IV heroin daily and crack, plus alcohol. Partner has concerns about the service user's mental health and paranoid thoughts.		
Bristol Drugs Project	18/02/2015		Theseus database / client file	BDP Shared Care Team	Internal ROADS Referral made to complex service (BSDAS)		
Bristol Drugs Project	19/02/2015		Theseus database / client file	BDP Shared Care Team	Appointment at HC - attended	Referral to BSDAS discussed. Dry blood spot BBV test carried out.	From notes Michael reports DV in relationship and pressure for unprotected sex. He has asked today for support in accessing men's crisis centre. I have given Michael the number and let him know

							he can self-refer and that they can call me for further information regarding his care."
S.Glos Clinical Commissioning Group	19/02/2015		GP Record	GP Practice 1	Michael seen by BDP practitioner 2. Blood borne virus screening done for Michael and partner. Michael is recorded as reporting DV in relationship and pressure for unprotected sex, asked for support in accessing men's crisis centre at █████. BDP2 gave contact details to Michael and advised they could contact her for information. IV heroin and crack use had escalated and so after discussion with GP Michael was referred to BSDAS. Blue script recorded as issued for pharmacy 5.		
Sirona Care and Health	20/02/2015	08:40:00	Minor Injury Unit	Sirona Care and Health	Daniel' attended MIU with injury to left index finger. Mild swelling. X-ray showed foreign body in pad of finger - thought to be small piece of porcelain embedded in finger.	Wound cleaned and dressing applied. Advised to consult GP if follow-up required.	
Bristol Drugs Project	23/02/2015; 24/02/2015; 02/03/2015		Theseus needle exchange database	BDP Engagement Team	3 needle exchanges recorded		
North Bristol NHS Trust	25/02/2105	N/A	Medical Record	North Bristol NHS TrustHand Service	Attended the Hand Centre at █████ Hospital for an x-ray. Michael did not return to the hand service after the x-ray.	Further appointment offered	Staff acted appropriately
North Bristol NHS Trust	02/03/2015	N/A	Medical Record	North Bristol NHS Trust Hand Service	Attended the Hand Centre at █████ Hospital. Patient now reporting it was a fall rather that punching a wall. Michael had removed the cast and back slab but still feels angle of the finger is odd.	Given further advice and another appointment to check progress.	Staff acted appropriately
Bristol Drugs Project	03/03/2015		Theseus database / client file	BSDAS	Letter sent with appointment date with BSDAS of 17.03.15		Date clashes with arranged final

							Shared Care appointment.
S.Glos Clinical Commissioning Group	03/03/2015		GP Record	GP Practice 1	Copy of BSDAS appointment letter sent to Michael received by practice		
S.Glos Clinical Commissioning Group	09/03/2015		GP Record	GP Practice 1	Michael's Hepatitis C and HIV results received by GP Practice 1 - both negative		
Bristol Drugs Project	09/03/2015		Theseus database / client file	ROADS BBV Nurse Specialist	Test results received and recorded - *HCV antibody NOT detected by dry blood spot testing* *HIV 1+2 antibody and p24 antigen NOT detected by dry blood spot testing.*		Result shared with patient and GP
North Bristol NHS Trust	11/03/2015	N/A	Medical Record	North Bristol NHS Trust Hand Service	Michael Did not Attend the appointment.	New appointment sent	Staff acted appropriately
AWP Bristol CJIT	17/03/2015		Theseus	BSDAS assessment appointment	DNA'd. Written to with a 10 day opt in letter. No response.		
Bristol Drugs Project	17/03/2015		Theseus database / client file	BSDAS	Michael DNA'd appointment		No communication received from Michael and so he was sent a letter giving him 10 days to respond
S.Glos Clinical Commissioning Group	17/03/2015		GP Record	GP Practice 1	Michael seen by BDP practitioner 2. Recorded as having missed BSDAS appointment that morning as he was not sure why he needed to see them. Advised about services needing to work together to support him. Michael directed to self refer to st Mungo's. Reported as still living with partner in South Glos but would be homeless otherwise. Blue script recorded as issued for pharmacy 5.		

North Bristol NHS Trust	18/03/2015	N/A	Medical Record	North Bristol NHS Trust Hand Service	Michael Did not Attend the appointment. .	Michael discharged from hand clinic. Letter to GP informing them of DNA's. Asking GP to refer if needed	Staff acted appropriately
Boots Pharmacy	23/03/2015		PMR	Boots Pharmacy	Last dose of recorded Methadone supply.		
Boots Pharmacy	25/03/2015		Pharmacist & PMR	Boots Pharmacy	Michael tried to collected a missed dose from 24/3/15 but as prescription had expired he was referred back to the prescriber for a new prescription	3/4/15 Note added to PMR indicating Michael had been aggressive with the pharmacist and possibly stealing. Pharmacist had a conversation with Michael concerning his behaviour and that if it continued we would ban him.	
Bristol Drugs Project	07/04/2015		Theseus database / client file	BSDAS	Lack of response from Michael recorded		Referral closed - meaning that treatment within BDP S/C continues
Bristol Drugs Project	08/04/2015		Theseus needle exchange database	BDP Engagement Team	Needle exchange recorded		
Bristol Drugs Project	14/04/2015		Theseus database / client file	BDP Shared Care Team	Appointment at HC - attended		Michael chose not to pursue self-referral to Crisis Centre, says that he is permanently staying in South Glos address and therefore needs to transfer to surgery local to address. Arrangements made for this to happen under 4 week transfer protocol

S.Glos Clinical Commissioning Group	14/04/2015		GP Record	GP Practice 1	Michael seen by BDP practitioner 2 who records a lack of progress in self-referral to St Mungos for housing. BDP 2 reports conversation with BDP 3 reflecting lack of progress and that Michael now living in South Glos so discussed transfer to new surgery. Copy of transfer letter for shared care services to GP practice 2 given to Michael. No further appointments for shared care offered at GP practice 1. 4 week blue script recorded as issued for pharmacy 4		
S.Glos Clinical Commissioning Group	15/04/2015		GP Record	GP Practice 1	Copy of transfer of Michael's care by Bristol ROADS Shared care service to GP Practice 2 received by GP Practice 1		The evidence of Michael's GP record shows that he did not register at GP Practice 2 as this would have sent a message automatically through the NHS primary care registration process.
DHI	24/04/2015	Not recorded		Developing Health & Independence (DHI), Bristol Recovery Orientated Alcohol & Drugs Service (ROADS)	Family and carer support triage completed by SG (DHI Family & Carer Worker). Michael's aggressive behaviour noted as well as concern about finances and chest pain. DE advised to see GP regarding chest pain.	SG booked assessment booked for 07/05/2015	Assessment did not take place
DHI	24/04/2015	10.04		DHI Bristol ROADS	Text sent from SG to Dan to confirm assessment date and time		
DHI	24/04/2015	10.3		DHI Bristol ROADS	Second text sent from SG to Dan to clarify parking arrangements for assessment		

Avon and Somerset Police	05/05/2015		Assist: AS-20150505-1098	Avon & Somerset Constabulary	Abandoned 999 call. On re-call goes to answerphone. Male then called back and said he did not want police, just wanted some advice. No further action.		
DHI	07/05/2015	12.37		DHI Bristol ROADS	Phone call from CMc (DHI Family & Carer Worker) to Daniel to inform him that SG was not able to complete the planned assessment that day. Daniel reported that his partner Michael had been arrested the previous night as Daniel had called the police due to Michael's aggressive behaviour. Daniel requested support to access Bristol Drugs Project (BDP) or Bristol Specialist Drug & Alcohol Service (BSDAS) to seek treatment for Michael. Daniel informed that SG would call him to make another assessment appointment.		
Bristol Drugs Project	07/05/2015		Theseus needle exchange database	BDP Engagement Team	Needle exchange recorded		
Avon and Somerset Police	07/05/2015		AS-20150507-0051 @ 01:40am Guardian: 46734/15	Avon & Somerset Constabulary	Verbal argument between Michael and Daniel, where Michael has taken 'crack' this evening and is disturbing Daniel who is trying to sleep.	Daniel was advised to recall if any further problems and Michael would subsequently be removed. DASH: DV Medium (officer perceived) Lighthouse tagged for support referrals if required.	
Avon and Somerset Police	07/05/2015		AS-20150507-0098 Guardian: 46849/15	Avon & Somerset Constabulary	Police were recalled by Daniel and Michael was subsequently removed from the address and taken to custody for 'Breach of Peace'. When police removed Michael, Daniel became upset in front of him and asked police offers why they were taking him and that he did not want Michael to go.		

Avon and Somerset Police	07/05/2015				Daniel advised offers there were 4 males in total living at the address including himself and Michael. The relationship between Daniel and the other males is unknown, however Dan may be taking advantage of younger men with drug habits, potentially funding their habits		
Avon and Somerset Police	07/05/2015				Following Michaels release from custody, Michael informed officers that he has been suffering physical, emotional and mental abuse for 5 months. This happens when Daniel is drunk. Michael refused to give further information.	Officers offered support agency referrals, but the offer was declined. Lighthouse was tagged. TAU marker placed on address. Referred to S.Glos MARAC for discussion on 21/05/15. Shared with First contact Adult Care information. DASH. DV High	
Avon and Somerset Police	09/05/2015		Guardian: 47793/15	Avon & Somerset Constabulary	Following Michael's arrest for Breach of Peace on 07/05/15, Daniel and Michael have not been seeing eye-to-eye. Arguments have continue over a payment made by Michael's solicitor of £17,000.00 which Michael believes to have been paid into Daniel's account. The money is compensation following a road collision that occurred prior to their relationship.	Verbal argument. No offences disclosed between parties. TAU marker for 12m already in place. Lighthouse has referred Michael to MANKIND for support. Beat Team are aware. Referral made to First Contact. This incident to be included in the MARAC 21/05/15. DASH: DV Standard.	

Avon and Somerset Police	09/05/2015		Guardian: 47793/15	Avon & Somerset Constabulary	Michael and Daniel were in a relationship and met approximately 7 months ago. Michael met Daniel via GRINDR, where he was advertising as a male prostitute to fund his drugs habit. Since meeting Daniel he has moved in with Daniel (prior to this, Michael had lived in Bristol area for 4 years). Michael is deemed to be at risk of emotional, psychological and physical abuse by his partner Dan.		
DHI	12/05/2015	14.56		DHI Bristol ROADS	Brief pre-assessment meeting with Daniel. Daniel reported being unable to make contact with BDP to arrange new methadone script for Michael. SG advised Daniel to attend BDP in person following the pre-assessment meeting. Daniel again reported chest pain and was advised to seek emergency GP appointment. Daniel also reported escalation in Michael's drug use. SG and Daniel agreed to meet fortnightly thereafter.	SG re-booked assessment for 15/05/2015	Assessment did not take place
SGC: Adult Safeguarding	12/05/2015	10.56	Police report received in Access team	Adult care, south Glos - Access team	Police report highlighted that Michael had been detained to prevent a breach of the peace. He disclosed that he suffers abuse from his partner. Concerns about his mental health	To gather more information	
SGC: Adult Safeguarding	12/05/2015	AM	Telephone call to PC to discuss the incident PC next on duty 15.05.15	Senior Practitioner, adult care Screening in Access team		Await further information from Police	

SGC: Adult Safeguarding	15/05/2015	AM	Telephone call from PC.	Screening officer	PC could not be certain whether or not Michael had any care and support needs but did feel that he was vulnerable. He felt that Michael was trying to disclose further abuse, but for some reason did not feel able to. PC is not certain if Michael has a mobile phone. Agreed that I will write to Michael offering an assessment as a means of providing an opportunity to engage with him.		
DHI	19/05/2015	16.15		DHI Bristol ROADS	Phone call from Daniel to worker to say that he had tried repeatedly to contact BDP but the phone lines were constantly engaged. worker then attempted to contact BDP on two different numbers but phone lines were repeatedly engaged. worker sought advice from line manager BMc (DHI Bristol Service Manager)who advised contacting BDP advocacy service and asking them to make contact with Daniel.	SG contacted BDP advocacy service	
DHI	19/05/2015	11.07 - 12.19		DHI Bristol ROADS	Text exchange between worker and Daniel. worker tells Dan that advocacy service will make contact with him regarding Michael, Dan confirms that they had just called. worker suggests that Michael requests Methadone script from his GP but Dan reports that Michael has not registered with a new GP. Following further advice from line manager worker suggests that Dan could encourage Michael to contact his previous GP.		

DHI	19/05/2015	No time provided		The Care Forum Advocacy Service	Phone call from worker to Daniel regarding Michael's methadone script. Worker confirmed that there had been technical problem with BDP phone lines which is why Dan had been unable to make contact. Daniel advised to re-contact Michael's previous GP for a repeat prescription and for Michael to register with a new GP in his area as soon as possible.		
Bristol Drugs Project	20/05/2015		Theseus database / client file	BDP Assertive Engagement Team	Michael presented at Advice Centre (with partner Daniel) as has no GP registration and therefore treatment has ended.		Advised by staff (in liaison with Shared Care worker) on how to register at appropriate surgery and re-start treatment. From notes: "Michael also spoke of wanting to leave his partner as there are issues of DV and control. Partner is engaging with DHI for support. Gave Michael details of Shelter and Bristol council for housing. Michael said that he would like to stay with a friend to feel safe, not sure where to register so advised if staying with a friend in that area or if staying at current address in s.glos."

SGC: Adult Safeguarding	20/05/2015	AM	Letter sent to Michael trying to engage with him offering an assessment of his care and support needs.	Screening Officer	letter sent to Michael	To try and make contact with Michael to establish what support and help he might need from Adult Care Services	
DHI	21/05/2015	14.22		DHI Bristol ROADS	Message left for Daniel by SG informing him of alternative contact number for BDP.		
SGC: Adult Safeguarding	21/05/2015	AM	Discussed MARAC	Senior Practitioner, Access team	Actions - Police to carry out welfare check and to advice Michael to register with a GP. Police to establish if anyone else at this address. To expect feedback to South Glos individual Safeguarding team.	Trying to make contact with Michael	
SGC: Adult Safeguarding	22/05/2015	AM	Telephone message from Michael to senior prac	Senior Practitioner	Message left from Michael confirming he had received letter and he would like someone to contact him but he did not leave a contact number.		
SGC: Adult Safeguarding	22/05/2015	AM	Telephone call to Michael	Senior Practitioner	Missed call number identified on phone, telephone call back to Michael on his land line. He was able to speak as his partner was out. He stated that his home situation was 'dire'- his partner is violent and he would like to leave. He is currently registering with a new GP. We arranged for him to come to Kingswood Civic Centre at 11am on 26/05/2015 to meet with a duty Social Worker to discuss his situation. This date and time was instigated by Michael	Able to make telephone contact	
SGC: Adult Safeguarding	22/05/2015	AM	Commenced Adult Safeguarding	Senior Practitioner	Michael is experiencing Domestic Violence from his partner for meeting with Social Worker to decide the best way to support him.	Appointment made to visit social worker, Michael appeared calm and said that if needed he was able to leave his home. The situation was assessed as not needing a same	

						day/urgent response.	
DHI	24/05/2015	10.33		DHI Bristol ROADS	Text received by SG from Daniel to acknowledge previous texts		
South Western Ambulance Service	24/05/2015	14:09		South Western Ambulance Service	We received a call on 24/05/15 at 14:09 to address to Daniel. The call got cut off and when the 999 call taker rang back they were advised, by a male with a different voice, that there was no ambulance needed and it must have been a mistake. Therefore we have no patient record as we did not dispatch an ambulance.		
Bristol Drugs Project	26/05/2015		Theseus database / client file	BDP Shared Care Team	T/C to Michael from worker, in response to e-mail received from partner ("Daniel") asking for contact to be made.		Confirmed that Michael yet to register at any surgery. Advice repeated of what was needed to do this and arrangements made for as timely an appointment as possible to be booked once registration completed, so that treatment could re-start as quickly as possible.

SGC: Adult Safeguarding	26/05/2015	AM	Discussion with Housing	Social Worker	Discussed possible emergency housing options that may be available to Michael, not clear at this stage whether he would meet the criteria for emergency housing, appointment previously booked for today - 11.00 a.m.		
SGC: Adult Safeguarding	26/05/2015	PM	Duty Social Worker follow up	Social Worker	Michael did not attend the meeting today at Kingswood Civic Centre as arranged. For follow up with MARAC and the Police to obtain more information, request for Welfare check.	To try and establish why he had not attended today's arranged meeting	
Bristol Drugs Project	27/05/2015		Theseus needle exchange database	Theseus needle exchange database	Needle exchange recorded		
SGC: Adult Safeguarding	27/05/2015	PM	Telephone call to Protect and 111	Duty Social Worker	Telephone call back from Police control who have reported they have visited Michael's home but no one answered, they confirmed they will try visiting again.		
Avon and Somerset Police	27/05/2015		Guardian: 34453/15	Avon & Somerset Constabulary	At 15:30hrs, at the motorway service station, Michael died of a drugs overdose. His partner, Daniel, who he lived with was present. They were on route to see Fleetwood Mac at the O2 in London. They stopped at services, where Michael received a phone call and disappeared for approx. 20 mins. On his return to the car, he was hallucinating, though he was having a panic attack, then began barking and screaming. Daniel informed officers he had never seen this behaviour before. Michael had a drug addiction and was also an alcoholic. Daniel had been trying to get Michael off drugs since they have been in a relationship and informed officers that Michael was on Methadone but had run out approx. 10 days prior.	The vehicle was searched and a needle was found.	

S.Glos Clinical Commissioning Group	28/05/2015		GP Record	GP Practice 1	GP3 records a telephone call from Coroners Office informing practice that Michael died in a service station on his way to a festival the day before. He was reported as "returning from the toilet looking unwell, collapsed and died." PM planned and overdose notes as being considered. Copy of medical record requested		
Bristol Drugs Project	28/05/2015		Theseus database / client file	BDP Shared Care Team	Informed by another client, and confirmed with GP, that Michael had died		
SGC: Adult Safeguarding	28/05/2015	AM	Contact with Protect	Duty Social Worker	Police have completed a welfare check/visit, but again no answer.		
SGC: Adult Safeguarding	28/05/2015	AM	Protect informed	Duty Social Worker	Michael had been found dead, query cause of death. We were advised that Michael death was not being treated as suspicious and there will be an inquest, further information will be available in due course.		
DHI	29/05/2015	16.5		DHI Bristol ROADS	E-mail to Daniel from SG containing information on enabling behaviours		
DHI	29/05/2015	16.56		DHI Bristol ROADS	Phone call from BDP to worker to pass on information regarding Michael's death. Agreed that BDP would contact police to inform them and ask that they contact Daniel.		
DHI	02/06/2015	11.55		DHI Bristol ROADS	Phone call from worker to Daniel regarding appointment with SG on 04/06/2015. Referral to Bereaved Through Addiction (BTA) discussed with Daniel for worker to pick up at next meeting.		
DHI	04/06/2015	9.1		DHI Bristol ROADS	Phone call to Daniel to cancel appointment with worker		
DHI	05/06/2015	11.3		DHI Bristol ROADS	Phone call from worker to Daniel to check in with how he was doing. worker agreed to call back later in the day as police were due to visit Daniel.		

DHI	05/06/2015	15.5		DHI Bristol ROADS	Phone call from worker to Daniel to discuss referral to BTA.		
DHI	05/06/2015	15.55		DHI Bristol ROADS	Text from worker to Daniel to inform him of BTA number.		
DHI	05/06/2015	15.57		DHI Bristol ROADS	Phone call from worker to DrugFAM to get advice on bereavement support for Daniel and to pass on his details as agreed with him.		
DHI	15/06/2015	15.2		DHI Bristol ROADS	E-mail from worker to Cruse to pass on Dan-iel's contact details as agreed with him.		
DHI	15/06/2015	15.27		DHI Bristol ROADS	Meeting between worker and Daniel to ex-plore how he was coping since Michael's death. Daniel's drinking and relationships with family members discussed as well as options for support for Daniel.		
DHI	17/06/2015	14.37 - 15.36		DHI Bristol ROADS	Text exchange between worker and Daniel to check how he was coping.		
DHI	22/06/2015	16.56		DHI Bristol ROADS	Message left for Daniel by worker asking him to get in touch.		
DHI	23/06/2015	15.55		DHI Bristol ROADS	Phone call from worker to Daniel to check how he was coping. Daniel confirmed that Cruse had been in touch.		
DHI	26/06/2015	15.2		DHI Bristol ROADS	Phone call from Daniel to worker asking for support to get a GP appointment as he was struggling to cope.	worker contacted GP and arranged duty doctor to call Daniel	
DHI	26/06/2015	14.55		DHI Bristol ROADS	Text from worker to Daniel confirm arrange-ments with GP.		
DHI	30/06/2015	11.42		DHI Bristol ROADS	Phone call from worker to Daniel to check how he was coping. Daniel confirmed he had seen GP and would be attending Cruse group, also that LIFT psychology had been recommended by his GP.		
DHI	03/07/2015	12.15		DHI Bristol ROADS	Text message from worker to Daniel to see how Cruse appointment went and asking Daniel to make contact.		

DHI	03/07/2015	14.27		DHI Bristol ROADS	Phone call from worker to Daniel to check how he was coping. Carers assessment in relation to Daniel's mother who has dementia discussed. worker and Dan agreed to meet on 08/07/2015 to complete carers assess-ment.		
DHI	03/07/2015	15.41		DHI Bristol ROADS	Phone call from BDP to worker to pass on in-formation about BTA group for Daniel.		
DHI	08/07/2015	11.53		DHI Bristol ROADS	Meeting between worker and Daniel to com-plete carer's assessment. Daniel's drinking discussed, he reported that his GP is aware of this. Agreed that worker would contact Daniel the following week for a check in call.		
DHI	27/07/2015	18.04		DHI Bristol ROADS	Message left by (DHI Family & Carer Team Leader for Daniel to check in and to inform him of BTA meeting dates.		